The Concept of Educational Music Therapy: Between Intuition and Implementation.

Thesis

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THE CONCEPT OF EDUCATIONAL MUSIC THERAPY:
Between Intuition and Implementation

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ABSTRACT

The investigation of this thesis is a conceptual analysis of the relationship between music therapy and music education. The stimulus for this investigation is the writer's(1) prospective concept of educational music therapy. The foundation of this investigation is largely theoretical and is complemented by empirical data.

Music therapy and music education are distinct yet related professions. Both utilise the medium of music with philanthropic intent. While the therapist, however, will seek to use music as a clinical intervention, the teacher will wish to address educational objectives. Yet at the heart of both professions lies the concern for the well-being of humankind and how the client as well as the pupil can realise life more fully through musical interaction.

In this thesis, consideration is given to inclusive environments within education. It is more likely today that pupils with special needs will be educated in mainstream schools. Consequently, it is more likely that music teachers will be required to engage with pupils across the whole spectrum of needs and abilities. However, while traditional methods of music education may not always be appropriate for those with special needs, an emphasis on therapeutic activities is dependent upon the availability of a music therapist. Thus, there would appear to be a need for music teachers to become familiar with therapeutic principles and practices. This need is the rationale for the writer's notion of educational music therapy.

From a theoretical perspective, educational music therapy is informed by recognised therapeutic principles of client-centredness, clinical intent and a concern for the promotion of health. Yet at the same time it is led by educational values of learning, skill

(1) The term 'writer' refers to the author of this thesis - i.e. James Robertson.

development and critical reflection. Educational music therapy is therefore a metatheoretical concept due to its evolution from a plurality of influences and its current perceived status between intuition and implementation.

From a professional perspective, educational music therapy aims for the *ideal* of a qualification that may be awarded to music teachers upon the successful completion of a programme of study which focuses on a therapeutic approach to music education. Ultimately, it is a systematic form of practice which can be implemented by music teachers for the benefit of pupils with special educational needs.

All of the above, however, needs to be considered within a heuristic framework. Educational music therapy is primarily a concept that is unlikely to be accepted within the current regulations of the Health Professions Council. This thesis, therefore, is an argument against this *status quo* on the grounds that the needs of teachers and pupils might be better served by the challenging of certain boundaries.

The investigation for this thesis is based on the writer's professional experiences, a review of literature pertaining to the fields of music therapy and music education and an analysis of data from interviews with people representing these two fields. The literature review comprises the main part of this thesis and provides theoretical and conceptual foundation while the material from interviews contributes empirical support. In the opinion of the writer, the prospective concept of educational music therapy - and how this may be differentiated with the more established understanding of clinical music therapy - represents the distinct contribution to scholarship that is required of this thesis. The review of literature and the interview data lead finally to the realisation of a continuum model which is a succinct and visual outcome of this mode of thought. This model is presented as the culmination of the thesis.

A justification for an educational approach to music therapy is made on the grounds that learning may be an intended outcome of therapeutic encounter and that the objectives of teaching can be health-related. For a certain population of pupils, therefore,

music may be a curricular subject that holds therapeutic significance. Consequently, for a certain population of teachers, educational music therapy might be a pathway that will ultimately enable them to take educational ownership of therapeutic principles.

CHAPTER 1 INTRODUCTION

1.1 Personal Motivation

The writer has been privileged to work within the educational sector as a music therapist in both special and primary schools, and also as a music teacher in a secondary school. Much of this thesis, however, has been researched throughout his period as a lecturer in music education (with a particular emphasis on heightening the appreciation by future music teachers of the principles inherent in music therapy) and, latterly, as a lecturer in music therapy. To date, therefore, this twin-track career has inevitably led to a consideration and evaluation of both fields. A refining of key principles has been a continuous outcome of this process. This has led to a further generation of questions and a sense of enquiry has proved to be a constant foundation for this research. Ansdell (2004) encapsulates this approach in general when he writes:

> What is genuinely new in the music therapy field in the last few years is the arrival of a systematic 'critical' or metatheoretical perspective on music therapy - exploring and evaluating how theory has been used in the construction of the discipline, profession and traditions of practice. (p. 75)

Presently, the writer is employed as a head of training for a Postgraduate Diploma in Music Therapy programme. This programme is situated within a school of education in a university. Furthermore, he is partly involved with students undertaking a Postgraduate Certificate in Music Education. By design, the two programmes share resources, accommodation and, to an extent, staff. Here then lies the potential for a dynamic professional context with regard to the interplay between music therapy and music education. It is clear from the responses of students training to become music teachers that, further to their desire to become aware of music therapy principles, they wish to adopt and adapt many of these principles due to the diverse needs and abilities of the pupils with whom they will likely be working. Furthermore, in the professional experience of the writer, music teachers of many years' standing are similarly interested, as for many

of them this convergence represents an increasing part of their professional responsibilities.

Thus, there appears to be a deficit in the availability of training at both pre-service and in-service levels. This has resulted in a certain inadequacy being felt by music teachers as they are required to inform and engage with pupils who may present the most severe or profound categories of needs. The writer believes that an introductory lecture or a series of workshops for music teachers concerning music therapy is insufficient. Instead, a re-examination of what constitutes effective music teaching within the sector of special needs is required. This is at least partly due to the fact that curricular developments appear to be indicating an evaluation needs to be made in order to distinguish between an educational intervention and a clinical intervention (Higher Still Development Unit, 1997). Is it possible, for example, to differentiate between a special educational need and a clinical need? Furthermore, should only a teacher be concerned with the former while only a therapist is called upon to work with, and attend to, the latter?

The answers to questions such as these go beyond the provision of extra resources such as specialised staffing or equipment. There is a sense, therefore, of a different approach being required in order to develop a therapeutic dimension to teaching and a form of education with clinical intent. It is through this quest for a clearer understanding of issues such as these that the personal motivation for the writer to undertake this research has evolved.

The investigation will largely focus on a meta-analysis of theoretical perspectives of music therapy and music education. Educational music therapy is itself a metatheoretical concept and, as such, would seem to contribute to the debate concerning definitions of music therapy *per se*. A context for this philosophical analysis may be found in the views of Stige (2002) when he writes:

> While . . . . definitions of music therapy should be developed at levels that are not exclusively linked to specific clinical theories and populations, I think that definitions

> inevitably will be informed by metatheoretical assumptions. Metatheoretical awareness will then be part of what will redefine music therapy in the future. (p. 203)

To illustrate these points in a more practical way, the writer now presents two snapshots of work undertaken that, at the time, appeared to suggest a radical departure from conventional music therapy practices. These represent important impulses for the current investigation. (For ease of reading of what is essentially a personal account, first-person singular pronouns are used in the following two sections. These are then followed by a reflection on their implications.)

1.1.1 Snapshot One: Island Inspirations

Following a visit to the Orkney islands in 1991, I decided to embark on a project that was subsequently entitled 'Songs of Orkney'. At this time I was working as a music therapist in a special school and a music teacher in a mainstream secondary school. 'Songs of Orkney' was an integrated arts project combining music, art and dance. After a period of approximately two months during which I worked with pupils from both schools at separate times, we rehearsed as one group and gave two public performances. This joint activity involved twenty pupils from the special school (almost the entire school population) and seven pupils from the mainstream secondary school.

This was different from conventional music therapy in that it involved working with a large group of pupils encompassing an unusually wide range of needs and abilities. Furthermore, while a context of weekly music therapy sessions was maintained for the pupils in the special school, there was also a deliberate teaching and learning of musical tasks. At the culmination of the project, there was a very clear removal from the privacy of the music therapy room to the public platform of the school assembly hall. Music therapy, therefore, was being represented by the performance of a product.

1.1.2 Snapshot Two : Differentiation on a Grand Scale

While working as a lecturer in higher education with students who were shortly to become music teachers, I regularly attended a local special school and undertook group music

therapy sessions with six children between the ages of seven and eleven years. In one particular year – after working with the children on my own for a several weeks – I took a group of fifteen students into the school to observe this work and, more importantly, to involve them in combined musical activities with the children. This featured an original song (based on a class topic) that required the children to play a variety of percussion instruments while the students played their respective orchestral instruments. We all sang the song together. A large part of the session, therefore, was based on the rehearsal of an original composition with differentiated parts. Furthermore, we often discussed some of the features in the music as a means of learning about the music – e.g. "did you notice how your hand chime parts were playing the same tune as the person playing the flute?".

This was different from conventional music therapy in that it involved the inclusion of a large group of students as part of a group music therapy session with six pupils. It also featured a particular emphasis on skill development, the understanding of musical concepts and working towards a finished product that was subsequently recorded and performed.

1.1.3 Variations on a Theme

While the theme was music therapy, the variations in both of these instances had a clear leaning towards music education. In so doing, the degree of adaptation on the part of the writer was such that, arguably, ethical considerations were being compromised. The apparent lack of confidentiality pertaining to the therapeutic relationship, the emphasis on a finished product and the public performance of this product meant that certain boundaries were challenged. And yet – on both occasions – it worked. No-one appeared harmed or offended. Indeed, on the contrary, an almost tangible personal growth could be observed in the responses of all who took part. There was a sense that, somehow, something new had occurred that had not been anticipated. Therapy and learning appeared to co-exist quite comfortably. While at the time the concept of educational music therapy had not yet evolved, a slight shift from traditional practices – in both fields – had been made.

1.2 An Attempt to Define Special Educational Needs

Due to the range of interpretations that may be applied to the term 'special educational needs', the writer considers it necessary to define, as far as possible, what is meant by special educational needs with regard to this thesis. Since the Committee of Enquiry into the Education of Handicapped Children and Young People (The Warnock Report, 1978), many policy documents and curricular guidelines have sought to provide teachers with advice on how best to meet the needs of pupils of all needs and abilities. These include the HM Inspectors' report (1994) *Effective Provision for Pupils with Special Educational Needs (EPSEN)* and *A Manual of Good Practice in Special Educational Needs* published by the Scottish Office Education and Industry Department (1999). MacKay (2003) explains how, as a means of identifying those pupils who were considered as having 'pronounced, specific or complex special educational needs which are such as require continuing review', as stated in the Education (Scotland) Act 1980, a Record of Needs was devised and implemented (p. 847). This was similar to the Statement of Needs applied in England. It is estimated that up to 20% of pupils may, at some stage, present a special educational need. Of this 20%, however, the number of pupils requiring a Record of Needs is considered to be approximately one in ten (MacKay, 2003).

Since the implementation of the Record of Needs, the conceptualisation of special educational needs has widened considerably. According to Furedi (2004) this is partly due to the increase in the labelling of children with a particular form of disability or disadvantage; a process, Furedi believes, that is often welcomed by the parents of children who may present characteristics associated with a learning difficulty. Furthermore, due to legislation such as the Children (Scotland) Act of 1995, the categorisation of special educational needs now includes individuals and communities affected by traumatic incidents and also by new populations such as refugees (Norrie, 1998). It is therefore difficult to be precise about the current number of pupils who appear to be regarded as having a special educational need. Yet it would appear safe to assume that the number is continually rising. The DfEE green paper entitled *Excellence for all Children - Meeting Special Educational Needs* (1997) states that, in England, the

number of children with a statement of special need rose from 153,228 in 1991 to 232,995 in 1997.

At present in Scotland the Record of Needs is being replaced by a Co-ordinated Support Plan (CSP). Unlike the Record of Needs, which was overseen by the psychology services and essentially followed a psycho-medical (or deficit) model, the CSP will more closely reflect the views and wishes of several agencies (MacKay and McLarty, 2003). With regard to this particular thesis, a question that may be asked is whether, in light of the circumstances and areas of development pertaining to an individual pupil, music therapy might be considered an appropriate intervention. In the opinion of the writer, such decisions may be informed by the multi-agency approach that is promoted by the CSP, and also a gradually heightened awareness of the agency members as to the precise nature and potential of music therapy.

Music therapy, therefore, may not be an appropriate intervention for all pupils who are regarded officially as having a special educational need (i.e. those pupils who have a Record of Needs). At the same time, it may well be appropriate for pupils who have not been categorised in this way to receive music therapy. Clearly, there needs to be a degree of compatibility between the kind of need presented and the recommended form of intervention. With this in mind, it is proposed that the term 'special educational needs' be used in its widest sense for this thesis. This will incorporate pupils with mild, moderate or complex learning difficulties, behavioural and emotional problems (including mental health disorders) and pupils who have been exposed to incidents of trauma either directly or indirectly.

1.3 Structure

1.3.1 Research Issue and Primary Research Question

As this thesis has a distinct theoretical emphasis, the majority of the investigation is to be found in the review of literature. The writer believes, therefore, that it is necessary to articulate the research issue and the primary research question in advance of this main section. This will provide a sense of focus for the reader and allow a clear link to be made between the findings pertaining to this primary question and the subsequent empirical data that is related to a subsidiary research question.

The key research issue is presented as follows:

A conceptual analysis of the relationship between music therapy and music education which, in particular, will examine the potential need for theoretical interdependence between these two fields.

The primary research question is presented as follows:

Within the literature selected for review, is there a motivation for theoretical interdependence between music therapy and music education?

1.3.2 Layout of Chapters

The review of literature (chapter 2) focuses mainly on the fields of music education and music therapy. The review commences, however, with a proposed therapeutic frame of reference within which the metatheoretical concept of educational music therapy may be situated (Combs, 1989). This is followed by a brief discussion of the aims of education and therapy in general. The purpose of this is to notice the degree of resonance between a key part of Combs' definition of therapy with educational principles; in short, to explore how *health* might be *taught*. This will then lead into the main part of the review of literature and acknowledge a sense of direction from the general to the specific.

Music education and music therapy are substantial fields within themselves and a specific focus will be made on how they each compare and contrast, and what the essential similarities and differences are. In particular, the emphasis that can currently be observed with regard to situated practice in music education (Elliott, 1995) and also in music therapy (Pavlicevic and Ansdell, 2004 and Stige, 2002) will be examined. The degree of theoretical interdependence between these two fields - actual and potential - is then discussed (Bruscia, 1998). An underlying theme of the review of literature is to notice if the writer's concern for the concept of educational music therapy is being supported - implicitly or explicitly - in the publications of different authors.

The choice of methodology, design and methods for the empirical dimension to this thesis are outlined in chapter 3. This includes discussion of the subsidiary research question, the findings of which help to inform the primary research question. The presentation of findings are made in chapter 4; this presentation describes - quantitatively and qualitatively - the responses of eleven people who participated in semi-structured interviews. In chapter 5 an analysis of these findings is made and discussed within the context of the earlier review of literature. An underlying theme of the analysis of empirical data is to notice if the writer's notion for the prospective concept of educational music therapy is demonstrated - implicitly or explicitly - in the concerns and aspirations of different practitioners.

In chapter 6, the implications of these theoretical and empirical findings are explored and a framework for the delineation between clinical music therapy and educational music therapy offered. This is the continuum model. In the conclusion to this thesis a case will be made - explicitly - to differentiate between these two perspectives on music therapy and so establish a need for a discrete training in educational music therapy to be made available.

The form of enquiry reported in this thesis may be summarised as follows:

- **Intuition** the writer's personal experiences and concerns (chapter 1);
- **Investigation**
  - *theoretical* other writers' concerns and opinions (chapter 2);
  - *empirical* the concerns, opinions and aspirations of a range of practitioners as expressed through semi-structured interviews (chapters 3, 4, 5, and 6);

- **Implementation** the establishing of educational music therapy (an outcome of chapter 6 insofar that it represents a focus for further research).

Therefore, as suggested in the title, this thesis represents the investigation between intuition and implementation.

CHAPTER 2 REVIEW OF LITERATURE

2.1 Introduction

The review of literature will mainly examine the views of a range of authors situated within the fields of music education and music therapy and seek to track developments from the second half of the 20th century to the present day. The choice of authors reviewed has been determined by books and articles to which the writer himself has felt professionally drawn and also by those recommended on the advice of his supervisors.

It seems pertinent to state that one motivation for choosing this research area is that, in the opinion of the writer, there would appear to be a shortage of literature which focuses specifically on the perceived overlap between music therapy and music education. There are several journal articles and sections within books that do acknowledge this overlap yet, in the U.K., there is not a great deal more. An attempt will therefore be made to review different international perspectives and also to consider the importance of different contexts within which music education and music therapy might be framed.

From the outset of this thesis, an underlying point is being suggested: that is, within music itself lies the potential for bringing education and therapy together. While this may not be the original intention of the composer or the performer, (and here only pre-composed music is being alluded to), the experience of the *recipient* is likely to be growth-related. Furthermore, such an experience need not be intellectually *cognised* for its value to be *recognised.* This appears to be the message Schubert conveyed when, in his song *An die Musik (To Music)*, he sets the words of Franz von Schober (Mandyczewski, 1985):

> You lovely art, in how many gray hours
> When I was ensnared in life's fierce circle,
> Have you sparked my heart to warm love,
> Whisked me away to a better world! (p. ix)

The above sentiments are also expressed by Paynter (1992) when he discusses the purposes of music. He writes:

> Music inspires us, entertains us, provides a blissful relief from the pressures of existence, calms us at moments of anxiety and comforts us in times of distress. (p. 13)

Notwithstanding the above, a music teacher or a music therapist is not seeking to transport a student or a client to a *different* world. We can only live in the reality of this world and at this time. Yet it may be *made different* through the experience of music. Furthermore, a music teacher and a music therapist will seek to make this 'better world' more than a temporary instance. The residue of the experience remains. It is hoped, therefore, that this review can begin to make clear how both these interventions have distinctive residues and how an identification of them may promote a form of professional collaboration while retaining a necessary degree of independence.

2.2 A Therapeutic Frame of Reference for Educational Music Therapy

In consideration of the Greek root of the word 'therapeia' (which traditionally means to attend, help, or treat) there is an implication that therapy might best be perceived not as a single entity but as stages along a continuum. Combs (1989) suggests that within an historical context there have been three different perceptions as to what the purpose of therapy is. He states that an early aim of therapy was essentially a means of rehabilitation, in which a person who was considered to be mentally ill attended therapy in order to become better. Secondly, Combs suggests that therapy became known as a means of prevention in which the counsellor or therapist sought to protect the client from the possibility of becoming ill. Thirdly, (and most recently), therapy is seen as a means of self-actualisation in which a person attends in order to acquire a greater sense of wholeness and integration. Combs' perceptions of therapy relate closely to the definition of health as presented by the World Health Organisation several decades earlier:

> Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. (World Health Organisation 1947, cited in Kiger, 1997, p. 6)

By considering therapy from the perspective of a continuum there is, potentially, the implication that if there is a line separating illness from wellness, then it should be perceived in a horizontal rather than a vertical manner; the line as a bridge rather than a barrier. In short, therapy is not something that one receives or engages with only when one is unwell but is a form of professional intervention that can assist everyone to feel more well. Therapy can be a safety net from serious illness but it can also be a springboard towards greater health. Reiff (1987) had referred to this earlier when he wrote of a new culture in which people, through the process of therapy, could be allowed to look inward as a means of acquiring a greater sense of personal happiness(1). Indeed, Reiff claimed that this was a different way of being and a new alternative to looking

(1) It should be noted that Reiff himself was slightly ambivalent about the culture of therapeutic values while still recognising its increasing prominence and popularity.

outward towards religion (or therapies of commitment) as a rationale for living itself:

> Ours is the first cultural revolution fought to no other purpose than greater amplitude and richness of living itself. (p. 241)

And later:

> Both East and West are now committed, culturally as well as economically, to the gospel of self-fulfillment. (p. 252)

While Combs did not appear to advocate therapy as a 20th century form of religion, he did maintain that the rationale for therapy was 'the universal need of the organism for maintenance and enhancement of self' (1989, p. 94). Thus, according to Combs there exists within each one of us the motivation to constantly move towards improved states of health; as human beings, he claimed, we are almost powerless to prevent ourselves from doing otherwise. Furthermore, for people who are predominantly healthy, the therapeutic journey will be a quest to understand oneself more fully, to discover personal meanings and to continue along the road towards self-actualisation. This would appear to accord with Maslow (1968) and his theory of need gratification which ultimately could lead to peak experiences. For Maslow, therapy was a process of continual growth towards such experiences even though clients may never acquire them, and even if they succeeded in doing so, they were by no means permanent conditions; optimum health, therefore, is never a fixed state.

Perhaps a degree of differentiation is needed here as we revisit our continuum. For there will be those who *need* therapy almost as a means of survival and there will be others who will *want* therapy to enhance their lives and so provide a clearer sense of personal meaning and values. To this the writer would add that there are those who would *benefit from* therapy when it is situated within an educational dimension. In his book *Client-Centered Therapy* (1998), Rogers includes a chapter entitled *Student-Centered Teaching* (pp. 384-428). He argues convincingly that while a therapist seeks to allow a client to 'deal constructively with his life situation', this should also be an educational objective and therefore an outcome of learning (p. 384). Rogers describes

this process as 'releasing' and claims that this can best be achieved when the therapist demonstrates a sense of 'acceptance, understanding, and respect' towards the client (i.e. client-centred) (p. 384). It is within this philosophy, in the opinion of the writer, that the interplay between music education and music therapy may be found. And it is here that the therapeutic frame of reference within which educational music therapy may be located and observed.

2.3 The Aims of Education and Therapy

By revisiting and rephrasing the three different perceptions of therapy presented by Combs (1989) as sickness-remover, sickness-preventer and health-promoter, there may be reasonable justification in claiming that, to a greater or lesser extent, these perceptions resonate closely with educational aims. In so doing, an attempt will be made to consider how health might be taught. An examination will now be made as to how these perceptions might compare and contrast with physical health, emotional health and mental health within an educational context. The rationale for highlighting these three areas is that each may be used to refer to a particular domain of health and the status of health therein; we may talk, for example, of someone being 'physically disabled', 'emotionally disturbed' or 'mentally ill'. As will be explained below, however, these are not end states in themselves but categories of health within which there will be different levels of ability depending upon individual circumstance.

2.3.1 Physical Health

Brewer (2003) writes of the shift that has taken place in education with regard to the teaching of physical health. The introduction of Standard Grade Physical Education in 1988 resulted in an increasing emphasis being placed upon the knowledge and understanding of health issues in addition to the teaching of health pursuits as found, for example, in sporting activities. The subject of Physical Education, therefore, was required to demonstrate accountable and assessable outcomes as in other subject areas of the curriculum. Furthermore, this was to be the responsibility of the physical education specialist as well as the general classroom teacher, in primary education at least. Teaching, therefore, as seeking to *promote* physical health is one means of fulfilling these aims. Furthermore, the intention should be that young people take this learning beyond the gates of the school and into their everyday lives through, for example, attention to diet and exercise (Scottish Executive, 2002). In this sense the teacher is a promoter of health.

Similarly, it would seem fair to suggest that in teaching a person about physical well-being, a teacher is aiming to *prevent* sickness from happening in the first place (Brewer, 2003). When one considers, however, teaching young people with physical disabilities, the more specialist advice of, for example, a physiotherapist may have to be sought. Such help might be required when the disabilities of the young person need to be prevented from becoming more prominent. In instances like this, specialist advice may be necessary to provide help in a directive manner to the afflicted individual as well as a means of consultative help to the teacher. Thus, the teacher still has a role to play and an aim to meet in the preventing of sickness.

The comparison of aims seems less robust, however, when considering the perception of teaching as a means of *removing* physical sickness. The precise nature of the physical illness will likely determine the form of intervention that is required. Certainly there are instances (a child prone to taking an epileptic fit, for example) when the teacher may be required to manage the sickness. But it appears here that the needs of the individual and the abilities of the teacher are such that a medical rather than an educational intervention is necessary. Kiger (1997) suggests that each individual person's status of health may be viewed as a moveable point along a continuum. By considering optimal health at one end and ill health (or disease) at the other, the need for a more specialised form of medical assistance with regard to physical health would appear to be required towards this latter end of the continuum. While there are increasing demands being made upon teachers to become familiar with a wide range of disabilities and disorders, the responsibilities pertaining to the removal of sickness would generally not come within the remit of a teacher.

2.3.2 Emotional Health

The teaching of emotional health, unlike the teaching of physical health, is not a discrete subject area within the curriculum; rather it is an implicit aspect of the curriculum as a whole. Mackenzie (2003) writes of the unfortunate yet inevitable labelling of pupils who are 'emotionally/behaviourally disordered' and how this term has replaced those used in the 1960s and 1970s of 'malajusted' or 'delinquent' (p. 878). According to Mackenzie,

current definitions include the 'vulnerable pupil' or the 'at risk pupil' (p. 878). Whichever label one chooses to adopt, it is the case that emotional and behavioral difficulties fall within the broad category of special educational needs.

If it is therefore acknowledged that pupils may present difficulties that are emotional in nature, how might emotional health be taught? One relatively recent development within education that has sought to address this area is that of educational therapy. The particular discipline of educational therapy was devised by Irene Caspari, an educational psychologist, in 1974. This led to the formation of the Forum for the Advancement of Educational Therapy and Therapeutic Teaching. Educational therapists are themselves experienced teachers who, having successfully completed further training, are awarded a Diploma in Educational Therapy. The programme outline for this course states that educational therapy is:

> . . . . a mode of treatment for those whose learning has been inhibited by emotional and social factors. (Forum for the Advancement of Educational Therapy and Therapeutic Teaching, 1997, p. 1)

This particular form of teaching is aimed at a specific client group within the population; that is, those with emotional, social and behavioural difficulties. Similarly, its essential goal is educational. Burridge (2000) reports that such interaction can have distinct benefits with students for whom remedial teaching has not been successful. Morton (2000) claims that educational therapy 'is a way of thinking as well as of working' (p. 39). She also emphasises the significance of the relationship between adult and child, and the strength required by the former to hold (rather than scold) the possible resistive response of the latter:

> Educational food can be rejected or remain undigested and just as an infant and mother can struggle with the feeding process, teachers can feel their offerings are rubbished by pupils or are rubbish. (p. 43)

What seems particularly pertinent to this discussion is the actual term 'educational therapy' and the description above of it being 'a mode of treatment'. Here we have a

form of interaction that draws equally from the domains of education and therapy to the extent that its title is inclusive of both. Furthermore, the deliberate use of the word 'treatment' would appear to satisfy the three conditions of sickness-remover, sickness-preventer and health-promoter.

As a means of promoting emotional health, the arts have a unique role to play. Witkin (1974), for example, writes of the intelligence of feeling and its potential for solving sensate rather than conceptual problems. For it is in the arts that particular scope lies for the development of feelings. If this is the case then one might infer from this notion that the development of feelings pre-supposes the expression of feelings; feelings have to be expressed before they can be developed. The arts, therefore, provide a means of expressing through active participation. Furthermore, the process of expressing is at least partly dependent on the use of one's imagination. One might suggest that imagination feeds the act of expressing feelings and lays the foundation for the subsequent development of these feelings. Graham (1998), however, believes that a careful distinction needs to be made between expression and expressiveness. While the former may imply a certain venting of emotions, the latter suggests an educative influence imbued with aspects of growth and development:

> Expressiveness, as opposed to expression, is artistic imagination providing us with a way of articulating something. What is important about expressiveness, however, is not that it has emotional content, because words and gestures and so on can be expressive of more than emotion, but that it enhances awareness. (p. 71)

This echoes the concern made by Hirst and Peters (1980) that creativity required to be distinguished from 'mere self-expression' (p. 32).

Thus, the promotion of emotional health may be seen as an outcome of acquiring a degree of artistic facility which allows the individual to be expressive *of* and *through* rather than *merely* expressing. This suggests that emotional health can be developed through the refining of expressiveness rather than the process of expressing raw emotion. In this sense, it would appear difficult to differentiate between education and therapy. A difference in intent, perhaps, rather than foundation. Therapy (and not only the arts

therapies) may be seen as a more appropriate context through which a sense of raw emotion can be naturally expressed; while education can further promote these emotions by the expressiveness of them through particular modes of response. The arts, therefore, represent one of these modes.

In order to consider how the teaching of emotional health may seek to prevent sickness, it is helpful to acknowledge different concepts of health education. Kiger (1997) lists these as the information-giving (medical model), the educational model, the propaganda (media) model, the enabling (community development) model and the political action model (p. 29). It is interesting to note that the process of information-giving is associated with the medical rather than the educational model; there is a notion here of the patient being a passive recipient of advice given by the doctor or another health-related professional. Furthermore, in order for the doctor to make a form of diagnosis, an examination or assessment (words commonly associated with education) must first take place. As will be discussed later, there is perhaps a fundamental difference between education and therapy through the deployment of assessment in the former as an end point while, in the latter, assessment is considered a starting point.

The educational model of health would seem to have been suggested by Dewey (1938/1997) when he claimed that:

> . . . . as far as the physician does occupy himself with instruction and advice as to the future of his patient he takes upon himself the role of the educator. (p. 76)

In schools, however, there are pupils rather than patients and there are teachers rather than doctors. Yet two points require to be made here. Firstly, there are discrete areas of the curriculum in Scotland where an emphasis on the promotion of emotional health and the prevention of emotional ill-health may be observed. These are in Religious and Moral Education, and Personal and Social Education. While the first of these may be considered to promote the necessity of a sense of personal values, religious or otherwise, the second implies a concern for the welfare and well-being of young people. Secondly, according to Goleman (1996), the actual teaching of emotion as a form of intelligence is something

that can be appropriately fostered within the environment of a school and permeate throughout the ethos as well as the curriculum of a school. Goleman suggests that the outcomes of the teaching and learning of emotional intelligence may be observed in the development of:

> . . . . abilities such as being able to motivate oneself and persist in the face of frustration; to control impulse and delay gratification; to regulate one's moods and keep distress from swamping the ability to think; to empathise and to hope. (p. 34)

One might take from this, therefore, that the teaching of emotional intelligence can be a successful means of preventing emotional ill-health. Thus, while all shades of feeling will be essentially felt, they need not be expressed if the act of expressing is of a negative or anti-social form. There is a certain tolerance and even promotion of accepting one's feelings or emotions rather than being compelled to either vent or suppress them.

Similarities may be drawn here with Gardner (1993) in his notion of the personal intelligences and, in particular, the intrapersonal intelligence. In his theory of multiple intelligences (1993), Gardner posits the view that intelligence is not a general state that may be used to define the intellectual capacity of an individual. Rather, intelligences may be observed through the abilities of different people and the particular domains within which they operate and perform, one of which is musical discourse(1). The development of intrapersonal intelligence (according to Gardner) allows the individual to detect and recognise one's own feelings and to be able to differentiate between them. He writes:

> The core capacity at work here is *access to one's own feeling life* - one's range of affects or emotions: the capacity instantly to effect discriminations among these feelings and, eventually, to label them, to enmesh them in symbolic codes, to draw upon them as a means of understanding and guiding one's behavior. (p. 240)

Both Goleman and Gardner are suggesting that these are attributes which may be taught by a teacher and, arguably, should be observed as explicit as well as implicit aspects of the curriculum. In so doing, one's emotional health may be actively promoted

(1) Gardner presents a list of seven intelligences; these are linguistic, logical-mathematical, spatial, musical, bodily-kinesthetic, interpersonal and intrapersonal.

while the potential for diminishing or preventing the occurrence of emotional illness may co-exist simultaneously. There appears to be an almost inevitable intertwining of *more of good* leading to *less of less good.*

Having briefly discussed the ways in which emotional health can be promoted as part of an educational paradigm, and how emotional sickness or ill-health may be prevented, a next step is to consider the potential removal of emotional sickness from the individual pupil. In attempting to do this, it is necessary to examine further what it is that actually constitutes a teacher. While a consideration of the specific roles of a music teacher and a music therapist will be discussed later, it is important to acknowledge that a teacher in general appears to be having to adopt generally therapeutic approaches as part of his or her everyday responsibilities. This may be observed, for example, in the process of differentiation whereby a teacher will adapt materials, techniques and responses to the needs and abilities of individual pupils. Indeed, this may be said to be a pervasive strategy and one that is representative simply of good teaching. Yet the context here is subject- rather than health-based.

McLaren (2003) is keen to highlight the particular significance attached to guidance and to Personal and Social Development (PSE), and their current status within the Scottish education system. In doing so he draws attention to the dilemma of, on the one hand, the real need for these areas to feature as part of the ethos and curriculum of a school while, on the other hand, the apparent low priority that is given to these areas as a result of 'increased emphasis on raising attainment and exam performance' (p. 447). This, according to McLaren (2003), is exacerbated by the relatively little amount of time allocated to guidance and PSE as part of Initial Teacher Education. The same author also notes the increasing and diverse responsibilities of teachers associated with these areas, ranging from family traumas to health matters. It follows, too, that teachers involved in such issues will often have to work with the parents of pupils as well as the pupils themselves. We may observe, therefore, the many roles of the teacher that include, to varying degrees, those of a counsellor and a social worker. A key point here is that

teachers are not normally trained counsellors or qualified social workers yet they are having to cope with health-related issues such as emotional difficulties that require to be acknowledged, managed and possibly removed.

Holden, in his book *Teachers as Counsellors* (1969), believes that counselling is one aspect of the general field of guidance. He is cautious, however, of the appointment of a professionally trained counsellor as this may set him or her apart from other teaching colleagues and potentially lead to friction rather than harmony between staff members. Instead, Holden proposes the notion of 'teacher-counsellor' (p. 193) as a means of working positively with young people who present a variety of needs and difficulties, including emotional problems. Yet he is aware that there is a limit to the amount of help a teacher-counsellor can provide especially when the difficulties that may be presented are of an extreme form. He writes:

> I am not advocating that I can cure my clients or condition them by some form of clinical therapy which is beyond my capability and therefore dangerous for me to essay. (p. 200)

Holden, therefore, is claiming that the process of curing (or one might say removal of sickness) is not in the domain of teachers or teacher-counsellors. There is a line to be drawn and it is then the responsibility of those with more specialist training such as therapists, psychologists and psychiatrists to be called upon and become involved. What is also interesting here is Holden's use of the word 'clinical'. Furedi (2004) widens the debate by discussing the apparent ascendancy of a therapeutic culture, in society generally rather than education specifically. In particular, he suggests an increasingly dominant feature within society is that of the expression and management of emotion. According to Furedi, individuals from all sectors are encouraged to show emotion and, in so doing, are more likely to be valued and respected. Attributes such as stoicism and the 'stiff upper lip' (p. 18) are less admired and almost actively disouraged. Furedi's main point, however, appears to be that this has resulted in confusion between what might be termed a generally therapeutic attitude that many of us can adopt, and therapy as a clinical intervention (p. 22). In the latter, a discrete professional training and, increasingly,

accreditation or registration will be required in order for the title of 'therapist' to be bestowed.

Just as was noted earlier with regard to the intervention of specialist help being necessary when a certain degree of physical ill-health requires to be managed, prevented or possibly cured, so too do we find a parallel in the area of emotional health. Thus, within the education system there appears to be emerging a continuum of health responsibilities that reflect the training, interest and expertise of individual members of staff. At one end is the general class teacher who, by means of differentiation, will sensitively adapt to the emotional needs of pupils; through to the promoting of certain emotional health issues by means of specific subject areas such as Personal and Social Development; then to guidance staff who may have to work with the particular emotional difficulties presented by individual pupils; and finally, at the other end of the continuum, the need to utilise the services of professionally qualified therapists, psychologists and counsellors to work with emotional issues of such severity that the training and experience of these people is considered indispensable. It is intriguing to observe, therefore, that in this population of professionals, three out of the four categories above comprise teachers. Emotional health would thus seem to be an aim and responsibility of education; only when the degree of emotional difficulty is considered severe (and clinical) does it become an aim of therapy.

2.3.3 Mental Health

There is perhaps an element of risk in attempting to discuss separately the areas of physical, emotional, and mental health. One might infer that each of these areas is exclusive and should therefore be regarded as a discrete health state. For many people, however, it is likely that a particular emphasis on one area may well be accompanied by a lesser emphasis on one or possibly both of the others. A person who has a physical disability, for example, may be considered quite likely to experience subsequent emotional difficulties as a result of having to cope with the initial physical challenge. Thus, there is a likelihood of interconnecting strands and inevitable influences that one health state may have upon the other. This would certainly seem to be the case in the area of mental

health; indeed, in many instances it would be a complex task to differentiate between emotional (or social) health and mental health.

One important aspect that needs to be considered with regard to mental health is that of terminology. Kiger (1997) outlines that potential for confusion exists by claiming:

> It is equally important to remember that patients and clients who are not designated as 'mental' or 'psychiatric' may also have learning needs related to mental health. (p. 271)

For purposes of this thesis, it would seem acceptable to replace either 'patients' or 'clients' with 'pupils' or 'students' and uphold the point that is being made here. Furthermore, Kiger is anxious to point out that mental health does not merely mean the absence of mental illness; one might not have a particular form of mental illness such as a depressive condition yet still benefit from the promoting of mental health. Particular aspects of mental health, according to Kiger, include the development of positive relationships and the ability to cope with stress.

According to the literature, there does seem to be justification in considering the promotion of mental health as an objective of a teacher while the preventing of mental illness may be a possible outcome of the promoting of mental health by a teacher or, in more challenging situations, a therapist. The curing of mental illness, however, such as a psychiatric condition appears to be in the domain of treatment rather than teaching and therefore is the responsibility of a professional clinician such as a therapist, a psychologist or a psychiatrist. In such cases, the form of intervention is likely to be medical rather than educational. There is also some justification in claiming that mental illness or mental health disorders are associated predominantly with adults rather than children. Conditions such as schizophrenia, anxiety and depression are more common in early adult years than in childhood (http://www.schizophrenia.com/family/sz.overview.htm. (2006))

In light of the above, it seems feasible to ask how the notion of mental health could be promoted within education. While it is not a curricular subject, how might it feature as an aim held by a teacher? Wilson (1969) claims that, to an extent, the human qualities of a

teacher are themselves an important means of promoting mental health. Such qualities are evident in the natural processes of a teacher noticing and enquiring as to how a particular pupil is reacting. It is this latter aspect that would appear to represent a conscious decision on the part of the teacher to 'ask for the reasons' (p. 67) why a child may be behaving in a certain way and seek to intervene if this is felt to be necessary. It is also a means of assisting and perhaps alleviating areas of difficulty or distress. Indeed, Wilson describes this process as 'curative' (p. 65). In this sense, it appears that Wilson is not wanting to restrict the teacher's concern to subject matters but to the child as a whole. As a result, the child may then begin to feel mentally better due to the acknowledgement and acceptance that has been demonstrated by the teacher. Wilson goes on to say that 'The good teacher characteristically identifies his pupil's feelings and prejudices, and adjusts or adds to them . . . . The work being done here is not unlike that of the psychiatrist' (pp. 71-72). Therefore, there are grounds for claiming that a shared aim of both the teacher and the therapist is a recognition of the individual person's feelings and the ability needed to educate, manage or guide these feelings as necessary.

To explore this more fully requires some consideration of what is meant by the notion of helping people to feel mentally better. Wilson appears to be suggesting that this entails helping people to feel better about *themselves.* This concurs with the views expressed by, for example, Maslow and Combs when they separately claim that the quest for self-fulfilment is a natural outcome of being human and, when this quest is arrested in some way, it can be the responsibility of more than one profession to resolve this issue. Indeed, Combs (1989) suggests:

> Helping people become more fulfilled, self-actualized, or healthy is what education, counseling, psychotherapy, and mental health are all about. (p. 64)

Yet other authors are critical of this view, at least to the extent that it is considered to be an educational as well as a clinical objective. Indeed, this would appear to be encapsulated in the concept of self-esteem: this implies that unless one possesses a respectable level of self-esteem, one will lack self-fulfilment and will not be as mentally

healthy as might otherwise be expected. Dawes (1994) claims that the correlation between self-esteem and academic achievement in education is unfounded. Hirsch Jr. (1999) writes that the giving of praise when it is not warranted may actually be a counterproductive strategy. This suggests that teachers, in attempting to prevent mental ill-health, are possibly exacerbating rather than alleviating a problem by providing undue acclaim. Furedi (2004) observes critically the significance attached to self-esteem as a result of contemporary therapeutic culture by pointing out that:

> A high level of self-esteem is symptomatic of a desirable state of mental and physical health, while a low level indicates that the self is ill and faces a crisis. (p. 145)

The above references imply that failure to promote mental health is equivalent to the failure to prevent mental illness. The task, therefore, to differentiate between the two seems almost elusive. According to Lasch (1991), the locating of mental health issues within the fields of education and therapy is an outcome of these agencies taking on responsibilities that were previously contained within the family unit. Lasch suggests that this has occurred not only as a result of the apparently diminishing significance of the family concept, but that social services, including education, foresaw a means of enhancing their own rationale and status by assuming greater control of these responsibilities. Issues of mental health and illness are therefore transferred from family to professional domains.

Yet when the debate is concerned with the curing of mental illness, a clearer distinction between the aims of education and therapy is observed in the literature. Curing, according to Hirst and Peters (1980) consists of:

> . . . . a family of processes, such as surgery, the administration of drugs, and so on, whose principle of unity is the contribution to the end of being better in respect of physical or mental health, ... (p. 19)

This, according to Hirst and Peters, contrasts with the family of processes that constitute education in which the principle of unity is the development of desirable

qualities. For these two authors, therefore, this represents a contrast in aims between the domains of health and education.

Wilson (1969) argues that within schools there is a need for 'The use of experts' (p. 75). In making this claim, Wilson cautions against a swift and simplistic view being taken whereby pupils with complex or serious mental health problems should automatically be seen by, for example, a psychotherapist, implying that pupils whose problems are less complex or serious can be attended to successfully by a teacher. Instead, the individual needs of the pupil concerned require to be carefully considered before a decision is taken as to who is most appropriate to manage and possibly cure the problems that are presented.

Wilson also believes that from the perspective of the pupil, it is important a clear boundary exists between teaching and treatment. If such a boundary is in place then it is easier for the pupil to know what the expectations of the school are and, in going beyond these expectations, when the intervention of a *non-school* person such as a psychologist or psychiatrist may be required. To clarify this boundary further, Wilson claims that if a child is to be cured then he or she must receive assistance from a neutral person in order to:

> . . . . get *outside* or *behind* the network of reactions to expectations which he has already developed and which is inadequate for the real world . . . . (p. 77)

In such instances, therefore, it would seem that the services of the neutral and external expert are required.

2.3.4 Summary

The review of literature thus far seems to be consistent in suggesting that the areas of physical health, emotional health and mental health, while portraying certain similarities, are distinctive in terms of their characteristics and manifestations. Furthermore, when considering the three different perceptions of therapy presented by Combs (1989) as sickness-remover, sickness-preventer and health-promoter, there appears to be a

consensus of opinion as to who is most suitably qualified to provide the form of intervention that is deemed necessary. Thus, it seems safe to conclude that while key aims of education might be to promote health and prevent sickness in each of the three domains of health, it is unlikely that the removing of sickness (curing) would represent an aim of the teacher. While the educational sector, by means of its teaching staff, is increasingly being asked to consider the general welfare and well-being of all pupils (through, for example, Personal and Social Education, guidance and various forms of learning support), there does seem to be a set of characteristics which indicate that in particular circumstances a different form of intervention is considered more appropriate. This set of characteristics is variable but appears to be placed at a point when the form of intervention requested is medical rather than educational, clinical rather than curricular, and when the professional person concerned is treating rather than teaching. Here, arguably, we have a new set of priorities and within these lie the aims of therapy. Now that these have been more clearly established, the discussion will focus on the specific fields of music education and music therapy.

2.4 Music Education and Music Therapy: An Opening Statement

2.4.1 Introduction

Whatever the differences between music education and music therapy might be, there are at least two clear commonalities: music and people. Both professions are *for* people and emanate *from* music. A key part of this review of literature will be to examine for *whom* certain applications of music are intended and, related to this, *who* is most suited and qualified to provide such applications. This interrelation of music and people is manifest whether the goals are predominantly educational or predominantly therapeutic. A brief consideration of these two primary components is given below.

2.4.2 Music

The opening melodic phrase of Schubert's *An die Musik* commences with a rising perfect 4th. The effect of this interval suggests a sense of assurance, a feeling of balance and a momentary sensation of looking forward. There is an impression of moving out yet still being contained within an overall notion of security. Similarly, Handel chooses this interval for the first two notes of his aria 'I know that my Redeemer liveth' from *Messiah*. There appears to be something entirely right about this; almost as if the words 'I know' could not possibly be set to any other successive notes. Indeed, Storr (1992) believed that a quality of all great works of art was this sense of inevitability; that it would be hard to imagine any well-completed work being composed in any other way (p. 179).

Yet, for Schubert, this was not the beginning of his song, *An die Musik*. A short piano introduction heralds the opening vocal phrase based mainly on a repeated quaver chord of D major in its 2nd inversion. The note A rather than D is at the bottom of this chord thus creating a sense of movement, of *ongoingness*. A chord in its root position would not have had the same effect; indeed, the music would appear to have concluded almost as soon as it had begun. Root position chords seem most suited for final cadences; the feeling of *groundedness* providing an appropriate sense of closure.

The above statements represent a personal attempt to depict - in words - two musical fragments of Schubert and Handel. A musical experience, however, is not dependent upon verbal cognisance; one does not have to know what a perfect 4th is in order to appreciate its unique effect. Yet different writers have attempted to encapsulate in words what a composer is trying to express in his or her music. Steiner's concept of intervals (1983) seeks to place the essence of different intervals, as far as possible, within verbal discourse. Cooke in his book entitled *The Language of Music* (1981) attempts to do just that: to define the experience of music through the written word. To justify this, Cooke argues that tonally based composers have - for centuries - deployed specific intervals, harmonies and rhythms in order to suggest certain emotions and experiences. And more specific to this thesis, Nordoff (writer, composer and music therapist), sought to harness and positively exploit the tonal language of music for clinical purposes (Robbins and Robbins, 1998). The challenge, however, of aligning verbal meaning to musical experience is descriptively portrayed by Cook (2000) when he writes:

> Music is pregnant with meaning; it does not just reflect verbal meaning. But words function, so to speak, as music's midwife. Words transform latent meaning into actual meaning; they form the link between work and world. (p. 121)

A key point the writer wishes to make is that within the supposedly separate domains of music therapy and music education, music itself is an essential common feature. The inspiration of music lies at the heart of both fields. While the particular ways in which music is used may differ depending upon whether the context is educational or therapeutic, music is the underlying force. In this sense at least, there can be mutuality and a sharing of territory. Music, in the hands of the educator, can *inform* people of the potential within musical components to create certain experiences. Yet this same music, in the hands of the therapist, can *assist* people to realise their potential more fully through the experience of certain musical components. Such desirable outcomes, however, do not belong exclusively to the domain of either teachers or therapists. As Duerksen (1967) writes:

> It is not the [music] teacher or [music] therapist who tells the person what to do; it is the music. (p. 96)

Likewise, Reimer (1989) claims:

> Music educators do not provide discipline or teach morality. Music does. (p. 140)

Yet within music education, according to Paynter (1992), is the requirement of the teacher to intentionally draw pupils towards a conscious learning and understanding of the material that is being presented. He writes:

> All conscious musical experience is concerned with adventures of feeling, imagination and invention. These features link composing, performing and listening, and should presumably be given some prominence in music education. (p. 13)

For Bruscia (1998), the intrinsic value of music itself can lead to experiences and rewards that are of extrinsic value: 'Art [or music] is therapy, even when not intentionally undertaken for that purpose' (p. 148). Similarly, Reimer (1989) suggests that it is often difficult to distinguish between a musical experience for its own sake and one where music is used for utilitarian purposes (p. 121). For Reimer, such purposes or ends should ultimately result in an aesthetic experience.

Furthermore, while the attempts of authors such as Cooke might verbally inform us as to how music used in certain ways can arouse particular feelings and emotions, such words will be an outcome of the experience rather than the experience itself. Likewise, in poetry, it is the words *of* the poem rather than words *about* the poem that speak to us most meaningfully and therefore affect us most deeply.

Swanwick (1995) points out that it is the expressive rather than the descriptive qualities of music that carry particular significance; it is 'free from literalness of representation' (p. 30). The metaphorical richness of music cannot be caught by words even when its contents are essentially programmatical or descriptive; there is something *else*. Similarly, Elliott (1995) discusses the difference between music that is expressional and music that is representational. While the latter may seek to depict non-musical events or ideas, the former can be a vehicle for human emotions; the capacity of musical patterns to 'evince the characteristics' of such emotions (p. 138).

Elliott's use of the word 'characteristics' is significant. For he appears to be suggesting that it is the characteristics (components) of the music rather than the music itself that contain and evince emotions. A piece of music by itself cannot be sad or exuberant; yet the composer can intentionally deploy the components of music to arouse such contrasting emotions. And for this to happen there needs to be interrelation between different sets of people; in particular, the composer, the performer and the listener. For it is *in* people that emotions are felt; and it is *from* and *to* people that emotions may be expressed.

2.4.3 People

In light of the above, the notion exists that a person may control yet also be controlled by music. Alvin (1975), for example, claims that music may be the servant but also the master of the ways of mankind (p. 162). In this sense, music can manipulate. Yet this involves the human process of manipulating (the composer and the performer) and of being manipulated (the listener, who may or may not also be the performer). And, as Duerksen (1967) comments, it is the accessibility and pervasiveness of music that allows:

> . . . . both the normal and the handicapped child to structure, or reconstruct, a part of his environment, and thus, to gain some control over it. (p. 96)

Isern (1964), when discussing the role of music in special education, appears to anticipate the views of Duerksen by claiming that regardless of the needs of those involved, the potential for differentiation of responsibilities and tasks within musical activities 'minimizes individual difference' (p. 139). Perhaps what is striking about musical exchange is its immediacy; the impact may not only be profound, it can also be instant. Thus, the 'I know' of Handel's aria may be collectively interpreted by those listening as 'we feel'. And just at that moment.

Within music education, Paynter and Aston (1970) allude to the significance of the whole person and how the benefits of this particular subject area require to impact in ways that are not exclusive to musical development. They write:

> Apart from those of us who are concerned solely with certain clearly-defined skills such as the techniques of playing musical instruments, the work of most teachers in schools is essentially a contribution to the *general* education of children. Even if a teacher finds himself working in a school as 'the music specialist' or 'the science specialist' he must not let this cause him to forget his first duty: the education of the whole person. (p. 2)

Therefore, while music is an essential feature common to music therapy and music education, so too is the involvement of people. This may be observed in the various forms of interaction *between* the providers (therapists and teachers) and consumers (clients and pupils), as well as the particular ways in which music can function *within* the human personality. This sense of the interpersonal and intrapersonal relates closely to Gardner's (1993) two-sided conception of personal intelligence discussed earlier.

With regard to the intrapersonal qualities of music, Swanwick (1996) discusses the potential of music to act as a bridge between the instinct and the intellect, thus affirming the 'feelingful *and* meaningful' aspects of music (p. 61). In this way, according to Swanwick, there is scope for music to mean something 'to' us in terms of its objective character as well as something 'for' us in the way that it can affect our capacities of thinking and feeling (1995, p. 114).

This point had been made earlier by Paynter (1972) when he emphasises the accessibility of the musical experience due its sensory and subjective components. He draws attention to connections between music, the individual and the environment within which the individual is situated by stating:

> [Musical experience] will increase his sensitivity to the world and educate that part of his intelligence that is concerned with *feeling*. (p. 10)

Parallels may also be drawn with Regelski (1981) when he discusses how music can 'contribute to or facilitate the process of individuation that is ongoing' (p. 62). Regelski is keen to emphasise here the uniqueness of each individual person and, in so doing, appears to echo the views of authors such as Maslow (1968) with regard to the striving of the individual towards self-realisation and the potential outcome of peak experiences. This is similar to what Csikszentmihalyi and Csikszentmihalyi (1988) describe as:

> . . . . optimal experience, autotelic experience, or flow. (pp. 3–8)

Music, according to Bruscia (1998), represents the 'art of expressing oneself in sound' (p. 62). Through the art and activity of musicing(1), a human being and music can become one. In the moment of musical expressiveness, a person's individuality may be demonstrated and observed. What is particularly significant about this notion is its prevalence; the accessibility of musical interaction is such that it is not dependent upon the prior development of musical skills or knowledge. All of us can *music*. Our inherent rhythmic and melodic tendencies expressed, for example, through our walking and our talking, suggest music. The human activity of music, according to Elliott (1995), is not only individually based but also culturally situated. He writes:

> A people's music is not only something they make; a people's music is something they *are*. (p. 197)

Elliott appears to be implying two things here: firstly, by claiming that the music people make is who they are, he suggests that people *are* music or that an individual person *is* music; secondly, if the individuality of a person may be expressed by his or her music, a person may be less than fulfilled on account of his or her possible solitariness.

For, as Elliott (1995) also writes: 'One person, like one rhythm, means nothing without the others' (p. 190). Therefore, for the client in therapy as well as the pupil in education, it is the interrelation with the other person(s) *through* music that can provide the most meaningful experience. This point is echoed by Cook (2000) when he writes:

> . . . . an approach that is based on the activity of music – of composing it, performing it, listening to it, loving it, hating it, in short, *doing* it – brings everyone involved in music into the picture. (p. 82)

(1) The term 'musicing' as deployed by Elliott would seem to originate from the similar term 'musicking' devised by Small in his *Music of the Common Tongue: Survival and Celebration in Afro-American Music* (New York: Riverrun Press, 1987).

2.4.4 Conclusion

Thus, we may be identified by the way in which we make music. To an extent, the music a person makes may be described as an aural form of DNA. We *sound* ourselves. Perhaps we sound ourselves most when we make our own music - when we improvise. For here we cannot *hide* behind the notes of another person. Furthermore, although our improvisations may be culturally situated, they are essentially self- rather than other-situated. This interrelation between music and people provides much scope for the therapist and teacher alike. Music has the potential to influence and inform, to alter and assist. On this basis, additional sub-themes of music education and music therapy will now be explored in greater detail.

2.5 Music Education and Music Therapy: A Consideration of Discrete Areas

2.5.1 Introduction

The writer does not intend to review the literature relating to music education and music therapy *per se*. The aim of this particular section is to examine the views of authors concerning the perceived commonalities and differences between music education and music therapy. Inevitably, this will involve relevant discussion as to what is meant by these separate areas, but this should be considered as supporting evidence relating to the degree of overlap between them. Thus, the reader is being asked to consider the following assumption:

- that the grounds for discussion of the perceived commonalities and differences between music education and music therapy are in the literature itself and, in the opinion of the writer, are sufficiently disparate and prevalent to warrant an attempt to synthesise these towards a shared focus.

The writer intends to structure this part of the literature review by arranging the accumulated views under the following four headings:

Motivations — the significant forces that appear to be indicating the need to debate and develop the relationship between the fields of music education and music therapy;

Influences — the historical and current influences that are framing the content of this debate;

Practice — the manifestation of this debate in terms of what it is that music teachers and music therapists actually do and the consequences thereof;

Training — the relationship between what practitioners have been trained to do and what it is that they are required to do.

2.5.2 Motivations

There would appear to be two significant factors that suggest the need to debate the overlap between music education and music therapy. These are policy motivations and professional motivations.

2.5.2.1 *Policy Motivations*

The word 'policy' implies a certain degree of authority. It suggests ideas and issues have been discussed and subsequently formulated into recommendations that are invested with the weight of a particular governing body. Colebatch (1998) claims that policy 'is seen as a way of bringing state power to bear on particular problems, and "policy" is the outcome' (p. 44). The deployment of the word 'problems' indicates all may not be well with what is currently taking place. Policies, therefore, are time situated as well as politically motivated.

With regard to this thesis, two government documents in particular have had a notable influence regarding the implementation of policy within education. These are *The Education of Pupils with Language and Communication Disorders* (HMI, 1996) and *A Manual of Good Practice in Special Educational Needs* (SOEID, 1999). One common theme is that of collaboration. Underpinning this theme is the notion that the model of a teacher as someone who is largely autonomous and professionally independent is no longer appropriate. There is a need, therefore, for a new model of professionalism that brings together distinct yet related fields and the individuals working within these fields. This may be observed, for example, in the development in Scotland of New Community Schools in which collaboration between different services is actively encouraged (Bloomer, 2003). Similarly, in schools where emphasis upon the community is perhaps more implicit than explicit, the movement towards collaborative ways of working is taking root (Milburn and Wallace, 2003).

In the Scottish Office recommendations (1999), emphasis is placed on the positive outcomes that can evolve due to active collaboration between the education and health services. Thus, teachers and therapists are being asked to initiate ways of working more closely as an outcome of national policy. While the HMI report (1996) is chiefly concerned with the form of inter-professionalism between teachers and speech and language therapists, it is reasonable to infer that therapists from other disciplines, who work in schools, should be encouraged to meaningfully collaborate with teachers. Forbes (2001) in discussing this report, notes that collaborative practices apply not only to professional trust and respect for each other, but to the joint setting of goals, working alongside one another and also to the possibility of training alongside one another. Indeed, Forbes claims that such shifts necessitate a radically new way of thinking as well as of working:

> Changed professional norms require that individual practitioners must also change in order to function as 'good' and 'productive' professionals. The new collaborative practice in school-based language provision requires a shift in individuals' values. (p. 203)

While the profession of music therapy may be younger and less prevalent within schools than speech and language therapy, there would seem to be a momentum within national policy developments to consider collaboration as widely as possible. Arguably, this is placing the needs of the individual before the perceived professional boundaries of separate forms of intervention. Furthermore, the fact that this is recommended to take root within training programmes is an important means of ensuring subsequent generations of teacher/therapist collaborative practitioners. Therefore, the motivation of policy is seen to be pervasive. And the outcomes of policy should ultimately be observed in the well-being of the individual pupils and clients themselves.

2.5.2.2 *Professional Motivations*

The sense of inter-professionalism mentioned above is itself an intended outcome of policy. Professionals from different disciplines are now being encouraged to work in new ways and in shared ways. Yet policy does not operate within a vacuum and it may be claimed that each new policy should be an outcome of professional practice. In this way,

one may be seen to be a consequence of the other and the motivations of both will continuously evolve.

The practical implementation of policies involves people. Yet this human intervention and interaction brings with it the possibility of people and professions *resisting* collaboration. While some will welcome and value the concept of inter-professionalism, others may feel that their boundaries have been professionally breached. A report by Welch, Ockleford and Zimmermann (2001) discusses the provision of music in special education (*PROMISE*). The authors suggest that the aims of music therapists have 'strayed from promoting "well-being" into what might reasonably be termed areas of education' (p. 12). The promotion of learning and development are cited by the authors as areas specific to education which appears to pre-suppose territorial boundaries between the two professions. Interestingly, the converse is not stated whereby the aims of music teachers have 'strayed' into what might be defined as therapeutic territory. The basis for this apparent one-sidedness, according to the authors, is that music teachers have not been especially required to work with pupils who have special educational needs: 'taking on pupils with learning difficulties is not something that the majority of teachers have in the past seen as part of their role' (p. 13). They do acknowledge, however, that this is gradually changing due to the current emphasis of integrating pupils with special needs into mainstream schools. Thus, we have the motivation of policy (inclusion) leading to the need for new professional motivations (clarification of aims).

Such professional motivations are likely to have practical consequences with regard to what practitioners actually do. One might suggest that a similarity of aims between music teachers and music therapists could lead to a similarity of outcomes; that it is simply the means to these particular ends that are different. Furthermore, if this is the case, then it may be proposed that the educational integrity and experience of teachers should become aligned to the clinical acuity of therapists and, in so doing, result in a higher quality of intervention. Therefore, the pupil can be the beneficiary of this form of professional collaboration. While boundaries - to an extent - may be breached, the outcomes could be highly desirable.

While Welch, Ockleford and Zimmermann (2001) suggest that it has not been the norm for music teachers to work with pupils who have special educational needs, it may be said that neither has there been a preponderance of music therapists to fulfil this role. According to the professional database of the writer, there are approximately thirty music therapists working in Scotland and about half of this number are engaged with this client population. Thus, it is safe to assume that the majority of pupils who have special needs are not receiving a sufficient (quantitative) amount of music education and/or music therapy. The acknowledgement of this fact indicates that there is a professional motivation to make this provision more sufficient both quantitatively and qualitatively. And it is in this latter aspect that there may be sound reason for the sharing of experience and expertise between both professions.

A study of the *Higher Still Arrangements for Music* (Higher Still Development Unit, 1997) appears to confirm this view. These arrangements represent a curricular framework in Scotland (post-16) for pupils of all abilities. The following points are considered as aims in music for those who present severe learning difficulties:

- to enrich the lives of students, and to contribute to their personal, intellectual, social and cultural growth;
- to develop aesthetic awareness and understanding;
- to highlight the communicative potential of interactive music-making. (Access 2, p. 2)

This third point would, in particular, appear appropriate as a central tenet of the process of music therapy. Yet it is difficult to see how music might be more meaningfully used by *teachers* when working with pupils who have special needs - especially those whose needs are considered to be at the severe, profound or complex end of the spectrum.

To an extent, the aims of music education do appear to be straying into the field of music therapy. Yet, in the opinion of the writer, this would seem to be a professional motivation rather than a deliberate attempt of one domain to intrude upon another. For it may be said that motivations arise out of needs, and needs arise out of our awareness of

people. It will not matter to the individual pupil whether his or her needs are labelled educational or therapeutic. Such needs are real and thus require to be met. If the quality of this meeting can be enhanced through a form of collaboration between teacher and therapist, then there would seem to be a professional motivation for this to happen.

In the discussion of professional motivations within the context of policies and practices in both Scotland and England, it is important to locate this within the respective professional journals that are published in Britain. It is surprising to note, however, that despite the potential demand to highlight and develop joint collaboration between both fields, there is relatively little journalistic literature that makes specific mention of this. Indeed, in the *British Journal of Music Therapy* (formerly known as the *Journal of British Music Therapy*) only three papers have been written since 1987 that refer directly to the role of music therapy within education.

Firstly, Strange (1987) writes of the additional responsibilities that the therapist may have to sensitively manage when working in a school for pupils with severe learning difficulties. While these responsibilities can sometimes clash with the conventional therapeutic role, an uncompromising avoidance of them may not endear the therapist to the team ethos that is often a hallmark of a special school environment. Strange recommends 'a trusting and open relationship with one's colleagues' otherwise a mutual misunderstanding can easily evolve (p. 31).

Secondly, Wilson (1991) discusses links between music and cognitive processes, and how music therapy can enhance the learning experience. In particular, she believes that the areas of sensory, physical, cognitive and emotional development, as well as social skills, can all benefit from the inclusion of music therapy within the educational setting. With regard to the interface between education and therapy, Wilson believes that 'good education becomes therapeutic' (p. 15) and this particular state is reached when priority is given to the concept of the whole child. She appears to fall short, however, of suggesting an active collaboration between music therapists and music teachers. One may reasonably deduce from Wilson's list of developmental areas which could benefit from

therapeutic intervention, that these are also likely to be educational considerations. There is a sense of an alternative hypothesis waiting to be made here by suggesting that good therapy might become educational. Furthermore, teachers may well take issue with the notion that some education may not be good and only education that is *good enough* can begin to be regarded as therapeutic.

The third paper is the writer's own (2000) in which the concept of educational music therapy and the notion of a continuum of interventions for music are presented. A central argument of this paper is that the needs of the individual pupil should determine the form of intervention. Thus, it should not be assumed that music therapy is only for those who have special educational needs while music education should be provided only for those who do not. Indeed, one might contentiously claim that if a pupil has a special educational need then it is the responsibility of the educator rather than the therapist to meet this need. The unpacking of this argument requires some clarification of terminology. In particular, it is reasonable to suggest that psychodynamically-oriented skills associated with a music therapist should be deployed towards needs that might be considered clinical while a teacher may be more concerned with needs that, essentially, are educational or *special educational.* Part of this thesis is an attempt to explore issues such as these more fully and more critically. In the opinion of the writer, there is a level of professional motivation that is moving towards a theoretical underpinning of educational music therapy as distinct from clinical music therapy. If this is the case, then it would appear that such theoretical underpinning might be the result of a degree of theoretical interdependence between music education and music therapy. The outcome of this would be the practical realisation of educational music therapy and the subsequent links with music education.

A response to this paper by Woodward (2000) was critical of the concept of educational music therapy. Her concerns appear more to do with sufficiency of training rather than the underlying professional motivation that seems to necessitate, if not collaborative ways of working between individuals, then at least collaborative ways of working within individuals. She writes:

> . . . . if one is to be an 'educational music therapist' one needs full training in both disciplines. My personal opinion is that the therapy is more important than the teaching, because learning and teaching opportunities arise naturally from the therapy. (p. 97)

While issues of training will be discussed later, this reference appears to place greater value on therapy rather than teaching simply because, in Woodward's opinion, the latter is an outcome of the former. Not only does this seem to contradict Wilson's earlier view that 'good education becomes therapeutic' (1991, p. 15) but it appears to take little account of whom either the therapy or education is for; that is, the pupil. Thus, there is a danger that professional motivations may be sidelined due to a certain degree of professional impulsiveness. This may be regarded as an understandable response to protect and confirm one's own professional standpoint.

Yet Woodward is surely right to highlight the importance of proper training and that issues of breadth and depth need to be fully acknowledged. Furthermore, this writer would agree with Woodward's view that learning can be an outcome of therapeutic exchange. It seems inappropriate to assume, however, that in generic terms, one form of intervention might be valued more highly than the other. A professional motivation should have its roots in the needs of an individual pupil or client rather than in the concerns of an individual profession.

In concluding this section, it appears reasonable to suggest that the policy motivation of inclusion of pupils with special educational needs may be seen as a rationale for the professional motivation of the development of integrative processes *within* the pupil. Consequently, such unifying and holistic tendencies may be observed in general as well as specific contexts. It is from this basis that Pavlicevic discusses the concept of an integrated experience in the *British Journal of Music Education* (1985). In this, she suggests that an integrated musical experience is concurrent with an integrated life experience and one can therefore benefit the other. She claims, too, that an acceptance of this stance has significant implications for the fields of both healing and teaching:

> Healing is no longer merely the eliminating of 'illness', nor teaching the imparting of 'knowledge'. Certain basic assumptions become open to question, including those of what constitutes integration, education, music and therapy. Our goals, our methods and our motives must be re-examined. (p. 157)

Such re-examination is a continuous outcome of professional motivations. And, clearly, this is as it should be.

In this section, the consideration of both policy and professional motivations has largely been contained within a national framework. This has helped to communicate a sense of the debate and developments that are current within the UK. In the following section, the intention will be to explore the different influences contributing to the perceived tensions of overlap between music education and music therapy. This will necessarily involve international as well as national perspectives. The increasing global prevalence of music therapy practice, as well as the diversity of music therapy approaches, has resulted in similar debates in other countries. To an extent, therefore, there is a momentum of dialogue that may also be observed in myriad forms of intervention.

2.5.3 Influences

This section will examine the historical and current influences relevant to the degree of overlap between music education and music therapy. A consideration will therefore be made of influences that impact directly or indirectly upon this central issue. This will include one of the educational roots of music therapy, one of the educational counterparts of music therapy and one of the therapeutic counterparts of music therapy that has a particular educational dimension. It will also include a consideration of two approaches to music therapy itself which, in the opinion of the writer, have a particular significance regarding the context of educational music therapy. These may be categorised as follows:

- Music in Special Education;
- Special Educational Music Therapy;
- Art Therapy;

- Community Music Therapy;
- Culture-Centered Music Therapy.

2.5.3.1 *Music in Special Education*

In 1964 the *Journal of Music Therapy* was founded in the USA and in its first volume a paper entitled 'Music in Special Education' by Isern was published. Isern focussed on those children regarded as being 'the trainable mentally retarded' (p. 139). She wrote of the potential of music to satisfy the ego; a point later acknowledged by Alvin (1975) when discussing music therapy. It is interesting to note Isern's concern for musical rather than non-musical goals and that she sees little difference between the responsibilities of the music teacher in special education and those undertaken in mainstream education. Yet she believes, too, that the emphasis should be on life beyond school: enabling pupils to find purpose in their leisure hours through musical experience and activity.

It was in the same year as Isern's article that in Britain the Carnegie Trust made possible the first short course concerning the use of music with children with special needs. One outcome of this course was the publication of *The Slow Learner and Music* by Dobbs (1966). This book, which was sub-titled *A Handbook for Teachers*, could be regarded as a catalyst for further thinking and subsequent writing in this field and indeed music therapy. While Dobbs makes particular reference to the recognised activities of singing, playing instruments, listening to music and moving to music, his views appear to anticipate the therapeutic concept of the music child (Nordoff and Robbins, 1977) when he claims that much of the responsibility of teachers is to:

> . . . . draw out from the child and nurture the elements of music which are already lying dormant within him. (p. 10)

Bailey, a contemporary of Dobbs, continued to develop some of these themes in his book *They Can Make Music* (1974). Here he adds the teaching of notation to the more traditional list of musical opportunities for children with special needs. In 1982, Wood wrote *Music for Living* and in the following year, *Music for Mentally Handicapped People* (1983) which considered a rationale for such work as well as providing teachers and

helpers with a considerable range of musical (and accessible) ideas. It is reasonable to suggest that most of the writing at this time was an outcome of the authors' own practical experiences rather than systematic guidelines associated with curricular frameworks. The relative infancy of special education meant that a certain trial-and-error approach in all subjects was the likely means of attaining more structured and standardised courses. The first one-year postgraduate training course in music therapy to be offered in the UK was established at the Guildhall School of Music and Drama in 1967. In 1968, the UK Carnegie Research Project led to the first *Music for Slow Learners* course directed by Dobbs at Dartington College of Arts.

Throughout the 1990s, books such as *Pied Piper - Musical activities to develop basic skills* by Bean and Oldfield (1991) and *Music Lessons for Children with Special Needs* by Perry (1995) provided a range of ideas for music teachers and class teachers alike. The implementation of the National Curriculum in England and Wales led to the publication of *Music for All - Developing music in the curriculum with pupils with special educational needs* by Wills and Peter (1996). The authors of this publication state the importance of an educational as distinct from a therapeutic context for musical intervention. The book is aimed at *musically-challenged teachers* and the suggested activities are related to the appropriate Key Stages within the National Curriculum.

Schalkwijk (1994) writes of the differences between the areas of music therapy, remedial music making (essentially the use of music in special education) and musical activities whereby music is used mainly for purposes of recreation. He concludes that, in general, music in special education will consider working towards a finished product as the main priority; music therapy, however, is more process- rather than product-oriented. Schalkwijk acknowledges that it is not always easy to differentiate in this clear-cut way and proposes, therefore, that the psychotherapeutic dimension of music therapy be highlighted. Thus, the term *music psychotherapy* should be adopted which allows sufficient distinction to be made between this and the therapeutic use of music as deployed, for example, by teachers in special education.

In 1996 the American Music Therapy Association published what would appear to be the most comprehensive volume of papers concerning the whole area of music therapy within education in *Models of Music Therapy Interventions in School Settings: From Institution to Inclusion* (Wilson). This makes reference to the historical development of music in special education from the 1800s. Issues that are discussed include models of service delivery (Johnson), in-service training (Heine) and different settings in which music therapy may take place: these include residential (Farnan), school-based (Coleman) and private practice (Griggs-Drane). The context of mainstream schools is also explored (Darrow) and particular reference is made to the consultative approach that a music therapist might adopt with a music teacher. This will be discussed more fully in the section entitled *Practice*.

In reflecting upon the literature above, there is a sense that music in special education and music therapy are different yet complementary forms of intervention and that both have their own sets of objectives and outcomes. To an extent, music therapy appears to be set apart from music in special education, with a boundary to protect and maintain this *apartness*. Welch, Ockleford and Zimmermann (2001) claim that the amount of literature specifically written concerning music in special education is 'relatively small' (p. 13) and that what has been written, in general, is historical rather than contemporary. Furthermore, the authors suggest that there is a dearth of literature pertaining to the use of music with pupils who have severe and profound learning difficulties. An exception to this would appear to be the work of Harald Goll (1994). Not only does Goll focus particularly on those who have severe and profound learning difficulties, he also proposes the merging of special education *with* music therapy. In so doing, he suggests the conceptualisation of Special Educational Music Therapy (SEMT), a brief review of which is now provided.

2.5.3.2 *Special Educational Music Therapy*

In his book *Special Educational Music Therapy with Persons who have Severe/Profound Retardation* (1994), Goll outlines a theory and methodology applicable to this particular client group. His synthesis of special education and music therapy means that SEMT,

according to Goll, is an 'adapted rather than a unique and independent framework' (p. 62). He is careful to emphasise the educational foundation of SEMT, to the extent that the term *music therapist* should be replaced by *music specialist* when the environment is one of learning rather than healing.

The basis of SEMT is the interaction between humanistic philosophy and the principle of normalisation. With this latter term Goll advocates strongly that the differences between people who have severe/profound retardation and those who have not are essentially quantitative rather than qualitative in nature. Goll maintains that this necessary shift in perception places the emphasis on society rather than the individual to make the required adaptations; this can then allow the individual to function within society with relative ease. According to this notion, therefore, a person only has a special need when that particular need is not being met.

Goll is critical of the more traditional (clinical) interventions of music therapy in which the terminology and environment appear to set apart the individual from society and may reinforce the perception that he or she is qualitatively different or inferior. Thus, he believes the music therapy experience should generalise to other situations and that the skills acquired are easily transferable. This would certainly appear to resonate with the inclusive philosophy promoted in current educational thinking and practice.

Where Goll seems to differ from music therapists of other traditions is in his concept of music itself. He states that, within the framework of SEMT, music should be used 'in its broadest sense' (p. vii). Unlike creative approaches to music therapy, for example, he appears not to promote the aesthetic or artistic dimensions of music but is concerned more with its functionality. He believes, therefore, that the implementation of breathing rhythms, vibration or 'the sounds of a jack hammer' (p. 108) should all be considered musically plausible. He writes:

> When education is the focus of SEMT, music is merely a tool. Therefore, the primary attempt of the music specialist is not to use music but to accomplish educational goals. (p. 105)

Therefore, while Goll is explicit with regard to aspects of terminology, attitude and theoretical influence, he is less than detailed when discussing the nature of musical encounter. It is intriguing, too, that he does not make mention of the particular training route a special educational music therapist should take or the level of musical expertise such training might require. Nor does he state if SEMT is applicable to populations other than those with severe/profound retardation. His direction is entirely educational and while he concedes that the overlap between therapy and teaching can make it difficult at times to distinguish between the two, he maintains that, like Maslow (1968), all efforts should lead towards the achievement of self-realisation.

What seems apparent in the two influences discussed thus far, (music in special education and special educational music therapy), is the suggestion that a finite number of client groups may act as consumers of either rather than both forms of provision. While the latter would appear relevant to those whose needs are considered severe and profound, the former seems more suited to pupils with mild and moderate learning difficulties. To an extent, there is a lack of pervasiveness with regard to the one underlying influence common to both approaches - music itself. Furthermore, while the areas of special education and music therapy are given due prominence, the larger area of mainstream music education is not. Thus, there would appear to be a missing link. If this link is the implementation of musical activities and experiences for pupils in mainstream education *including* those who have special needs, then a substantial gulf has yet to be bridged. This is the gulf between music education and music therapy. The earlier motivations of collaboration and inclusion suggest that the bridging of this gulf should not simply be a desirable option; rather, it should be a mandatory procedure that has the therapeutic and educational well-being of young people at its heart. A review of the literature concerning the ways in which this procedure might be realised will be discussed more fully in the section on *Practice*. Prior to this, three further areas will be explored and their relevance to the central theme of overlap considered.

2.5.3.3 *Art Therapy*

A comparison with developments in art therapy would appear to make sense as the professions of both music therapy and art therapy can be suitably compared in terms of historical progress and clinical application. From its beginnings in the 1940s, art therapy has had close association with the fields of art education and psychotherapy. In 1969, a pilot scheme for training emerged at St Albans College of Art which later developed into a Certificate in Remedial Art. In 1976, a training course in art therapy was recognised by the British Association of Art Therapists at the School of Art Education in the University of Birmingham. The possible crossover between art teaching and art therapy has been discussed by Waller (1996) when she suggests that the differences between the professions are primarily institutional and professional rather than fundamental. Similarly, Fuller (1996) believes that while there is a need for two separate professions, it would be unfortunate if positive interchange between them was not encouraged. Laing (1996) takes this further by presenting the view that the educational and therapeutic dimensions of art should be regarded as complementary to one another and thereby feature at either end of a spectrum. She writes:

> From the educational end of the spectrum towards the therapeutic, the arts include technical skills, craftsmanship, experimentation of media, study of the history of art, art appreciation, self-expression, spontaneous image-making, psychotherapeutic art. (p. 145)

The clinical and educational dimensions of art therapy have also been acknowledged in opportunities for training. In Goldsmiths' College (University of London), the Postgraduate Diploma in Art Psychotherapy, until recently, could be taken either as a Clinical Mode or as an Educational Mode. Qualified art teachers who wanted to work as art therapists in schools were able to follow this latter route of study to obtain qualification (Goldsmiths' College, Postgraduate Prospectus, 1999).

While it is not the intention of this thesis to outline potential structures of training courses in either music education or music therapy, it would appear that the academic

implementation of art therapy in both clinical and educational forms does have historical precedence(1).

Brandt, Wohler and Aldridge (1991) write of the similarities and differences between both therapeutic modalities through the analysis of a patient's response to treatment after receiving regular independent sessions of both music therapy and art therapy. They highlight the value of this form of research as being of ultimate benefit to the patient rather than wishing to attain 'the glorification of our own disciplines' (p.16).

In conclusion, while collaborative ways of working between teachers and, for example, physiotherapists or speech and language therapists are relatively established, it is interesting that this does not seem to be the case in the arts therapies. Indeed, what appeared to be particularly significant about the direction taken by Goldsmiths' College with regard to art therapy training was that it seemed to be *profession-directed* - at least in terms of clinical and educational influences. There was a sense here of what might be described as *distinctive differentiation* and that the profession of art therapy was both theoretically and practically concerned with tailoring the therapeutic application of art to the needs of practitioners as well as of clients.

2.5.3.4 *Community Music Therapy*

While the term 'Community Music Therapy' (CoMT) is relatively new, the implementation of this approach to music therapy would appear to be less so. Roots may be observed in Scandinavian music therapy, most notably in the writings of Ruud (1998) and Stige (2003). Pavlicevic and Ansdell (2004) claim that much of the work of Stige throughout the past twenty years has been - in practice - representative of CoMT although it was not until 1993 that he began to attach this title to his work. There would appear, however,

(1) It is the understanding of the writer that due to the state registration of arts therapies in recent years and the need for training courses to be approved by the Health Professions Council, the opportunity for different modes of training (as made available for student art therapists at Goldsmiths' College) is no longer available. Thus, an individual who holds the title 'art therapist', 'music therapist' or 'dramatherapist' is, under present legislation, considered fit to practise in all potential areas of work.

to be an increasing groundswell of practice that has led to a heightened sense of CoMT as a tangible approach to music therapy within the international community.

The publication of *Community Music Therapy* (2004) by Pavlicevic and Ansdell is representative of the pervasiveness of this approach throughout the world and that a shift appears to have taken place regarding its conceptualisation. Like Stige, therefore, many authors who have been independently practising what might be called Community Music Therapy are now labelling it thus. At the heart of this debate is the perceived challenge of CoMT upon what might be termed the 'consensus model' of music therapy. This represents the more established forms of music therapy in which client confidentiality, privacy, the emphasis on the therapeutic relationship and an adherence to psychodynamic principles may be observed. In attempting to define CoMT, however, Ansdell (2003) states that it is:

> . . . . an anti-model that encourages therapists to resist one-size-fits-all-anywhere models (of any kind), and instead to follow where the needs of clients, contexts and music leads. (p. 3)

Ansdell is suggesting here that any definition of music therapy must take into account the context and environment in which it is being practised; indeed, that it is situated practice. This would seem to link closely with the views of Elliott (1995) where, in his discussion of music education, he advocates strongly an awareness *of* and emphasis *on* the context in which learning is taking place.

The prospective concept of educational music therapy may be said to be a potential sub-category of the more established concept of Community Music Therapy. Indeed, educational music therapy is concerned with the theory and practice of music therapy within an educational context. To be more specific, educational music therapy is school-situated. And it may be argued that if a music therapist is to work in a school, then he or she must demonstrate a certain resonance with the school in terms of its ethos, values and aspirations. A music therapist, therefore, is part of the school community; the school itself is part of the wider community and of society in general.

In particular, there are three areas that feature regularly in Pavlicevic and Ansdell's publication (2004) which appear to imply a closer collaboration between music therapy and music education. These are the development of musical skills, the significance of musical performance and the debate concerning the relative emphases of process and product. While these three areas may contain several links, a brief discussion of each will now be presented. The purpose of this is to consider whether a precedent is being set within Community Music Therapy for a specific educational sub-category.

2.5.3.4.1 *Development of Musical Skills*

The emphasis that is placed on active musical participation between a therapist and client might well have an effect on the level of musical skill that is being acquired by the client. Familiarity may lead to a certain degree of technical finesse when one is musically involved. It seems reasonable to suggest, therefore, that an outcome of regular music therapy interaction is the development of musical skills. Such an outcome, however, may not have been an initial objective. Wood, Verney and Atkinson (2004) appear to have made a conscious decision to highlight the development of musical skills in their three-stage programme entitled 'From therapy to Community' (p. 51). This places therapy and community at either end of a continuum with the intention that a client might move *from* therapy *to* community by means of progressively tailored musical activities and experiences. In the second and third stages of this programme there is an increasing emphasis on the gaining of musical skills and knowledge. The underlying motivation here is the gradual development from individual to group-based contexts.

A similar view is taken by Amir (2004) when she asks, 'Can there be a continuum between music therapy behind closed doors and communal performance?' (p. 260). Her supervision of music therapy students and music therapists draws her to the conclusion that an individualised approach to music therapy is not conducive to encouraging clients to feel more community-oriented. In particular, she believes that the musical responsibilities of a music therapist should include a concern for the 'musical life' of clients beyond the music room (p. 265). An example of this is her aspiration for music

therapists who are working in schools to take on a greater responsibility for the musical life of the school. This would probably include an emphasis on the development of musical skills. Such a view would concur with the opinion of Boyce-Tillman (2000) when she seeks to counter the perceived argument that musical skills in music therapy should not be intentionally sought. She writes:

> . . . . some clients can benefit from acquiring musical skills and information and to a certain extent will automatically acquire greater musical skill by engaging in music-making activities. (p. 229)

One might infer from the above that a music therapist need not feel apologetic about making the enhancement of musical skills a therapeutic objective. Indeed, this may lead to a sense of liberation on the part of the therapist through the acceptance of musical learning as having clinical potential.

2.5.3.4.2 *The Significance of Musical Performance*

The development of musical skills may benefit further from the opportunity to perform these skills. The challenge of performance will likely provide the impetus for the refining of skills. To perform, however, is often associated with to *make public* and, within the 'consensus model' of music therapy, this is neither appropriate nor ethical. Here, the privacy of the client is being compromised and the therapeutic relationship negated. Yet, once again, context is the deciding factor. Powell (2004) argues that such performances should only take place when they have been 'planned in advance and happen when the time is right for both the clients and the institution' (p. 179). The music therapist, therefore, must decide for whom and at what point in time, performance is a desirable objective. Turry (2001) highlights the sense of achievement that a client can acquire as a result of a successful performance. He writes:

> The performing process can bring up new issues and areas of development, which feed back into the therapy process. Experiencing a sense of being valued and being attended to after the performance by the therapist, clients can feel an internal sense of validation and nurturing that can be more powerful than the public response. (p. 10)

According to Turry it is not simply the performance itself or indeed the process leading up to the performance that can have therapeutic value but also the residue of the experience after the performance. And it is important that this is 'attended to' by the therapist. Thus, performance itself is a process.

Aigen (2004) takes a similar view and states that, for some clients, the best way to address their needs is through the activity and challenge of performance:

> It seems like your personal process necessitates the public performances because it's the best way of addressing the things that you came to therapy for. (p. 209)

The perception of performance-as-therapy - while being encouraged by certain music therapists and their clients - may not always be welcomed by other members of the multi-disciplinary team. Maratos (2004) makes this point when describing the sense of disapproval that was conveyed to her by colleagues in a hospital setting. Indeed, some considered this to be 'anti-therapeutic' (p. 143). Yet, with regard to this thesis, it may be argued that this perception is less likely to be felt within an educational setting. It is not uncommon for music therapists to be asked to contribute to the performance life of a school. In settings where the medical model of health is emphasised, however, the music therapist may have to convince his or her colleagues of the value of taking therapy outside of the therapy room. As Zharinova-Sanderson (2004) notes, the therapy room is - ultimately - an unnatural environment for music-making to take place (p. 243).

On reflecting upon this issue, it appears that the notion of performance in music therapy has resumed a level of significance that was first observed in the earlier years of the profession. In their book *Therapy in Music for Handicapped Children* (1973), Nordoff and Robbins discuss the value of writing music and musical plays for children that can be publically performed (e.g. *Pif-Paf-Poltrie*, Nordoff and Robbins, 1969). Arguably, such activities became less prominently featured as music therapy adopted closer links with psychotherapeutic principles and frameworks. Community Music Therapy, however, appears to have widened the boundaries of music therapy practice to embrace performance as a possible objective in certain contexts. It may be suggested, therefore,

that educational music therapy is a particularly appropriate context in which this can purposefully flourish.

2.5.3.4.3 *The Emphases of Process and Product*

In considering references in the music therapy literature which emphasise the importance of the therapeutic process, Bruscia (1998), for example, writes:

> Music therapy is a process that takes time: It is a sequence of experiences leading to a desired state, rather than a single event that has an affect. (p. 33)

While this view would be strongly validated by those who lean towards the 'consensus model' of music therapy, it is unlikely that people wishing to promote the concept of Community Music Therapy would disagree with the essence of this statement. Indeed, in the opinion of the writer, it would seem that CoMT is not in dispute with the 'consensus model' but is wanting it to embrace a wider range of possibilities and experiences. Furthermore, the writer believes that one possibility is a specific educational dimension or sub-category.

As discussed earlier, the inclusion of performance as part of a client's therapy programme can have clinical value. Performance is one example of a product. Care needs to be taken, however, to ensure that ethical considerations are maintained. Turry (2001) warns that the attainment of this kind of product should be for the well-being of the client and not a means of gaining approval or recognition on the part of the therapist. The underlying principle should be that performance is seen as 'part of, not the end product, of the music therapy process' (p. 4).

There are other examples of a how a product might feature as part of the therapeutic process. One of these is the process of songwriting leading to the finished product of the song itself and, possibly, the recording of the song. In her work with patients who are terminally ill, O'Callaghan (2005) writes about the language of guided songwriting. Essentially, this is a shared activity between therapist and patient focussing on the significance of words and music through the medium of song. The tangible product of, for

example, a recording of a song can represent a treasured object that friends and relatives of the patient may then be given. Similarly, Turry (2001) cites the work of Ramsey as another example of working towards a product within music therapy (p. 9). Through engaging with clients who are neurologically impaired, Ramsey uses the activity of multi-track recording as a means of bringing together the process and product components of therapeutic interaction.

An observation that is made by Pavlicevic and Ansdell themselves in the final chapter of their book *Community Music Therapy* (2004) is that the predominance of work discussed is concerned with adult clients. This appears to have been due to circumstance rather than choice (p. 301). Yet this seems to make the case for educational music therapy more compelling. Arguably, the context in which young people are most frequently located is within the school setting. By embracing the curricular emphases that comprise the culture and community of a school - and steering these when appropriate with therapeutic intent - the concept of educational music therapy may be a logical route to follow. The activities mentioned above of skill development, performance and working towards a product such as a recording or composition are clearly embedded within the music curriculum. For those pupils who may benefit from - yet have some difficulty in attaining - an involvement in these activities and experiences, a form of music teaching that is therapeutically led may be highly desirable. Community Music Therapy, therefore, seems to naturally herald an educational sub-category.

2.5.3.5 *Culture-Centered Music Therapy*

In similar ways, culture-centered music therapy(1) may be considered an appropriate frame of reference for educational music therapy. Furthermore, like Community Music Therapy, it is concerned with situated practice and the need to consider the different

(1) In accordance with Stige (2002), the writer is deploying the word *centered* rather than *centred* and is maintaining lower case for the first letter of each word - i.e. *culture-centered music therapy.* This contrasts with the use of capital letters in *Community Music Therapy* as preferred by Pavlicevic and Ansdell (2004).

environments, contexts and cultures in which people are located. Not least, it takes account of the plurality of musics that furnish our communities in increasingly diverse forms. Stige (2002) encapsulates this neatly when he defines culture-centered music therapy as 'tolerance for diversity in the broadest meaning of the word' (p. 2).

Stige, however, is keen to emphasise that culture-centered music therapy is a theoretical perspective rather than a practice. Indeed, he suggests that a metatheoretical critique be applied as this facilitates the notion of theorising *about* theory and encourages the practice of reflexivity(1). Therefore, like Pavlicevic and Ansdell, Stige is not seeking to condemn traditional approaches to music therapy; rather, he suggests openness to the needs of people in the places in which they live and operate.

Within the context of music therapy, Stige (2002) defines culture as 'the accumulation of customs and technologies enabling and regulating human coexistence' (p. 38). This promotes the significance of human beings positively interrelating with one another. This links closely with the views of Ruud (1998) and his concern that the concept of health involves not only administering to the needs of the individual but also to the communities and cultures within which individual people exist.

A point of note within this discussion is the extent to which music is considered a universal language. For if it is, then this may arguably diminish the relevance being attached to different cultures - musical and otherwise. While music (and to a lesser degree music therapy) may be a global phenomenon, the values and meanings attached to music may not be universally shared or culturally recognised (Bruscia, 1998, Cook, 2000). From a music therapy perspective, therefore, it is important that clinicians are sensitive to these issues. And here, too, the issue of human development is pertinent. While Trevarthen (1997) claims that within each human being there exists a form of universal

(1) Stige (2002) describes reflexivity as 'The ability to think of oneself in relation to others, which for humans is enhanced greatly by the operation of signs belonging to cultural systems' (p. 335).

experience related to aspects of tempo and phrasing (p. 97), Stige (2002) argues the case for the non-universality of music. Thus, while the desire to organise musical expressions is universal and may have biological roots, the different ways in which these musical expressions are organised will be culturally informed; indeed, they will be culturally specific.

Parallels may be drawn here with music education. Elliott (1995) seems to be implying the need for culture-centered music education when he claims that 'music listening [within music education] always involves cognising musical expressions of culture-specific information (including cultural beliefs and values.)' (p. 191). Indeed, it may be argued that contemporary music teachers are well placed with regard to cultural issues due to the prominent status now given to world musics within education. As a requirement of the music curriculum, it is reasonable to suggest that music teachers need to be culturally *sensitive* to the diverse range of pupils with whom they will be working and culturally *informed* in order to satisfy and enhance their musical development. Kwami (1996) is anxious to promote 'intercultural' understanding in which music education respects the skills and background of all pupils equally (p. 61). He writes:

> A comprehensive education programme needs to recognize that deviations do not equate with inferiority and that diversity can contribute to a rich and more meaningful tapestry of life and experiences. (p. 61)

Culture, however, does not only apply to other nationalities and societies. We each have our own cultural perspective and background. Within the Western tradition of music education, the musical culture of young people will largely be influenced by a wide range of popular music styles. While studies show that playing and listening to pop music can provide benefits associated with enjoyment, creativity and imagination (North, Hargreaves and O'Neill, 2000), Boyce-Tillman (2000) is concerned that pop music is 'endangering diversity by the globalisation of capitalistic value systems' (p. 256). Instead, she recommends that music education should seek to enhance pupils' respect for musical diversity.

To an extent, a key issue here is to do with *place*. A school is a set of communities and cultures that are located - even for a few hours each week day - within a fixed spot. Hence, there will be a dynamic interplay between these communities and cultures. The peripatetic context within which many music therapists work - and the relatively small number of pupils they will see in comparison to a music teacher - should compel the therapist to purposely become an integral member of this set of communities and cultures. The benefits of this are reciprocal as an enhanced sense of identity within the *place* of a school will ultimately be seen in the *partnerships* and *practices* between all concerned.

In conclusion, culture-centered music therapy should not be considered as curriculum-centered music therapy or class-centered music therapy. Yet a music therapist working within music education is also working within the cultures of curriculum and class contexts. Here lies the potential for diversity and, as Stige (2002) states, 'Music Therapy as Cultural Engagement' (p. 118). He writes:

> '[The therapist] may need to combine music therapy models with approaches developed in related fields, such as music education, performance, and counseling'. (p. 118)

One potential combination, therefore, may be an educational dimension to music therapy. Indeed, music education may be considered a possible 'port of entry'(1) for music therapy (Stige, 2002, p. 149). This may then help to promote a degree of theoretical interdependence between music education and music therapy - thus justifying the metatheoretical critique of educational music therapy itself.

In the following section, the review of literature will focus on what teachers and therapists of music actually do and the subsequent educational and clinical outcomes of their work.

(1) While Stige does not explicitly state that music education might be a potential 'port of entry' for music therapy, the writer has inferred from Stige's general views - and his deployment of this term - that he would be supportive of this notion.

2.5.4 Practice

In his book *Defining Music Therapy* (1998), Bruscia proposes the following as a working definition:

> Music therapy is a systematic process of intervention wherein the therapist helps the client to promote health, using music experiences and the relationships that develop through them as dynamic forces of change. (p. 20)

This succinct definition would seem to satisfy a range of music therapy methodologies. While the approach taken may be creative, analytical, behavioural or Guided Imagery and Music (GIM), Bruscia's careful choice of words is respectful of and prevalent within the main international models of music therapy. A particular challenge in the attempt to define music therapy, according to Bruscia, is that it is 'transdisciplinary' in nature (1998, p. 6). Furthermore, as a profession that is still in its relative infancy, definitions (as well as approaches) are continuing to evolve.

While Bruscia acknowledges the challenge of finding a sequence of words that is sufficiently pervasive, it is reasonable to suggest that music therapy as an intervention cannot take place without the three essential components of music, a therapist and a client. Although the degree of musical involvement by the therapist may vary considerably depending upon the approach being used, a therapist has to be present. Likewise, the music itself may be improvised, pre-composed, pre-recorded or listened to (in the presence of a therapist) but it must somehow feature as part of the client-therapist relationship. And without a client there is no rationale for therapy. Yet if the words 'therapy', 'therapist' and 'client' are respectively changed to 'education', 'teacher' and 'pupil', it is intriguing to consider the appropriateness of Bruscia's definition when altered and applied to music education:

> Music *education* is a systematic process of intervention wherein the *teacher* helps the *pupil* to promote health, using music experiences and the relationships that develop through them as dynamic forces of change.

In the opinion of the writer, it is difficult *not* to agree with the above as a definition of the practice of music education. At the same time, however, it appears insufficient as an exclusive definition. Music education is not only about promoting health; arguably, neither is music therapy. There would seem to be a difference in intent that will largely be dependent upon context.

The issue of intent is suggested as a key difference between music education and music therapy by Lane and Joyner (1999) in an initiative developed as part of their work for the Fulton County Music Therapy Programme in Atlanta. In discussing the role of music therapists in a music education setting, Lane and Joyner claim that:

> . . . . any music education activity can be therapeutic in its goal and any music therapy experience can be educational. It is all based on the intent of the teacher/therapist. (information sheet)

The fact that the word 'any' is used suggests not only an overlap but an impartiality of activities and experiences associated with both fields. The difference, according to the above, is in direction of content rather than choice of content. And the wider context with regard to content will probably be client- or population-based. Thus, while there are books entitled *Music Therapy for the Autistic Child* (Alvin and Warwick, 1991), and *Music Therapy in Palliative Care* (Aldridge, 1999) it is less probable that authors of books pertaining to music education will publish in these essentially health-related fields. Yet when music therapists do write books that appear to be intended for a wider readership, the word 'therapy' is often not included in the title - e.g. *Creative Music in Groupwork* (Achenbach, 2002), *Music in Geriatric Care: A Second Look* (Bright, 1991) and *Music for the Hearing Impaired and Other Special Groups* (Robbins and Robbins, 1980). This is not to suggest that such books are not intended for music therapists; rather, they are not *only* for music therapists. Arguably, the current emphasis on policies of inclusion suggests a marketplace exists for books that explicitly focus on, for example, music education for children on the autistic spectrum.

In general, therefore, there appears to be a notable degree of inconsistency in the literature when the commonalities and differences between music education and music therapy are discussed. This is evident between the writings of different authors as well as within the writings of the same author. Bruscia (1998) would seem to feature in this latter category. He is clear, for example, when outlining the differences between the two fields. These differences may be extracted from the main body of Bruscia's text within the format of four assertions:

- 'In music education, music learning is the ultimate goal; in music therapy it is a means to an end';

- 'In music education, the goals are aesthetic or musical first, and functional second; in music therapy, the goals are health-related first, and aesthetic or musical second';

- 'In music education, emphasis is given to the universally shared world of music; in music therapy, emphasis is given to the person's private world of music';

- 'In music education, the student-teacher relationship is limited to musical concerns; in music therapy, the client-therapist relationship addresses health concerns that can be addressed through music'. (p. 177)

To the extent that a music teacher is required to follow curricular guidelines and standard assessment criteria, one may be inclined to agree with the general tenor underpinning Bruscia's assertions. Yet one might infer that he presents a rather simplistic stance in his attempt to outline the differences between both fields. Furthermore, within this same book, Bruscia often appears to be more embracing of educational dimensions within music therapy than is suggested above. While on the one hand it seems that he is confident about the essential differences between music therapy and music education, he is certainly not dismissive of the therapeutic impact upon the learning process. Indeed, he devotes an entire chapter to the consideration of *Didactic Practices* (pp. 175-191). He

precedes this by outlining what he believes to be the different levels of practice. These indicate the 'breadth, depth, and significance of therapeutic intervention and change accomplished through music and music therapy' (p. 162). This organisation of levels helps to clarify the different dimensions of therapeutic intervention through the medium of music. Bruscia specifies these levels as follows:

- '*Auxiliary Level:* all functional uses of music or any of its components for non-therapeutic but related purposes.

- *Augmentative Level:* any practice in which music or music therapy is used to enhance the efforts of other treatment modalities, and to make supportive contributions to the client's overall treatment plan.

- *Intensive Level:* any practice in which music therapy takes a central and independent role in addressing priority goals in the client's treatment plan, and as a result, induces significant changes in the client's current situation.

- *Primary Level:* any practice in which music therapy takes an indispensable or singular role in meeting the main therapeutic needs of the client, and as a result, induces pervasive changes in the client and the client's life'. (p. 163)

There is a clear indication above (with the exception of the primary level) that music therapy need not be considered in exclusive terms. It is only at the auxiliary level that Bruscia does not actually include the term 'music therapy'. This would seem to have the effect of making less distinct the boundaries between music therapy and related practices. Bruscia appears to be promoting diversity and acknowledging that, in certain circumstances, music therapy may have greater influence when used alongside another form of intervention.

In light of this, the interface between music therapy and music education might be appropriately situated at the augmentative level. To take this literally, music therapy at this level is being used to augment the learning programme of the student. Arguments may be justified against this on the basis that an assumed comparison is being made between Bruscia's use of the phrase 'treatment plan' and the writer's own deployment of 'learning programme'. On the basis, however, that an Individual Education Plan (IEP) for a pupil with special needs will require consideration of how these needs can be best met,

the terminology of 'treatment plan' would not seem inappropriate. Thus, the particular cognitive needs of the student may be assisted through the application of music therapy. Bruscia himself claims that:

> . . . . the role of the music therapist at this level frequently includes the role functions of other professionals (e.g., teacher, minister, or other type of therapist). Generally, this is determined by what goals have been established as priority within the area of practice or clinical setting. (p. 168)

Once again, particular significance is attached to contextualisation. There is an implicit need, therefore for a music therapist to regard each area of his or her work through a specific lens, one of which has a distinct educational focus. Indeed, intentionally or otherwise, Bruscia appears to have laid the foundations for different modes of music therapy. At the primary and intensive levels there is a clear need for music therapy to be regarded essentially as a clinical intervention. The augmentative level, however, while still clinically informed may be educationally directed. As noted in the earlier discussions of culture-centered music therapy and Community Music Therapy, this level might be directed in a range of ways.

Within the context of music therapy, a link may be observed between Bruscia's primary and intensive levels and the definition of the word 'clinical' as presented by Wigram, Pedersen and Bonde (2002):

> A term which refers to the identification and attention to symptoms or other aspects of an illness. It can also refer to an approach where one is scientifically detached and strictly objective. The term is used in music therapy in reference to clinical improvisation. (p. 316)

At this point, it seems appropriate to explore the views of other authors with regard to Bruscia's four assertions pertaining to the differences between both fields. This will also include a critique of the essence of each assertion from the perspectives of music educators. In particular, it will be interesting to observe if either an implicit or explicit demand for an educational dimension to music therapy will be evident. These four assertions will now be taken in turn.

1 In music education, music learning is the ultimate goal; in music therapy it is a means to an end.

An examination of literature relating to the above claim needs to be considered within the context of when it was written. Just as approaches to music therapy have continued to evolve throughout the past half-century, so too have theories and practices of music education. This should be borne in mind, for example, when considering the following opinion of Gaston (1968), one of the earliest proponents of music therapy in the USA:

> Perhaps music therapy and music education can best be distinguished by the fact that the music therapist is chiefly concerned with eliciting changes in behaviour, not with perfecting musical endeavour. (p. 292)

Gaston's use of the word 'chiefly' appears to sit well with the considered use of intent discussed earlier. In addition, the sense of 'perfecting musical endeavour' suggests an emphasis upon aspects of performance within music education in contrast with the activities of creating (or inventing/improvising) and listening.

Alvin (1975), however, appears less willing to lend support to the notion of intent, suggesting instead that there is the need to 'draw a line between music education and music therapy' (p. 104). Music, according to Alvin, represents the aim of the study in education whereas in therapy it should be regarded as a means to non-musical ends. One might infer from Alvin's comments that the study of music involves a certain degree of musical skill development. Additionally, it seems reasonable to deduce that the line Alvin wishes to draw between the two professions would be more akin to a barrier than a bridge. Similarly, Ansdell (2000) is keen to differentiate between the two fields when he writes:

> Almost every music therapist would deny that their aim is, like the music teacher's, to improve the client's music. Many would, in fact, see this to be the last thing they do . .' (p. 3)

Jellison (1979), however, believed that while music therapists would most frequently be concerned with the need to 'teach non-music goals necessary for independent living'

(it is intriguing to note Jellison's use of the word 'teach'), their roles may eventually be required to broaden in order to include the development of 'music goals with emphasis on longitudinal curriculum planning' (p. 130).

The opinions of Paul Nordoff and Clive Robbins, according to Aigen (1996), appeared to fluctuate when comparing the pioneering work they did in music therapy with the practice of music education. On the one hand, Robbins is quoted as telling students that 'it is a mistake to dilute your work with educational aims' (p. 21), while on the other hand, Nordoff claims 'Some children can take a little teaching, some can't. It depends on the child.' (p. 21). Aigen himself is quite clear that certain aspects of the Nordoff-Robbins approach to music therapy are concerned with the acquisition of musical skills, not least when the activity in question is the singing and playing of pre-composed music. Yet, in the opinion of Aigen, the main purpose of this focus was for the enhancement of emotional experience rather than the development of musical skills *per se*.

Michel (1985) believes that while the development of musical skills will be the concern of the teacher rather than the therapist, this process may be regarded as a catalyst for the two professionals to work together in a collaborative way. He proposes, for example, that the development of self-esteem could be a particular objective shared by the teacher and therapist alike. By encouraging the development of certain skills, children could learn an instrument such as a guitar and thereby increase aspects of confidence and identity. While the teacher could oversee the day-to-day implementation of the musical activities, the therapist might be better used to measure progress, analyse the subsequent data and then advise upon procedures to facilitate a transfer of skills into other areas of learning. In this way, suggests Michel, 'the music therapist then would be functioning as a special resource person or consultant' (p. 31). It is interesting to reflect on this professional arrangement in which the teacher will seek to *develop* skills and the therapist may then attempt to *generalise* these skills.

This issue of skill development in music therapy is also discussed by Codding (1982). The priority here is the development of life skills and that music therapy (as well as the

relationships within the process of music therapy) 'facilitates the learning of necessary life skills' (p. 22). It is worth noting that Codding is referring particularly to children with visual impairments.

Perhaps this is what Bruscia is implying when he discusses music therapy as a *means to an end.* The fact that he refrains from suggesting what the *end* might be, may be taken to mean that it will depend entirely upon the needs of the individual person. Bruscia, it seems, is wanting to emphasise that needs should not be confused with musical deficits. Thus, he would likely agree with Codding's concern for life skills as an objective within music therapy. Similarly, Krout (1986), in his desire to promote the potential of music therapy to develop social skills in the special education setting, would presumably be supported by Bruscia.

At the same time, although Bruscia is anxious to point out what music therapy *is not*, he is also positing a view as to what music education *is*. While it is unlikely that music therapists would agree with the notion that their prime concern is the development of musical skills, various music educators appear to question the importance of this objective in their own work. Regelski (1981), for example, writes:

> It is an apt time for music to resume the humanizing function lost in those settings where skills, facts, and information have been taught as ends in themselves. (p. 185)

Similarly, Finney (1999) claims that music education will 'remain deficient until it sets about clarifying its humanistic role' (p. 243).

These two references suggest developments in music education have led to an erosion of its humanising principles; that they were once there but now they have gone, sacrificed in the development of musical skills for no ends other than their own. This would appear to be a rather bleak assessment although the question may then be asked, that if this is indeed the case, has music therapy replaced what music education once had? The *personal* relevance of music, according to Regelski (1981), should not be withheld from its educational implementation:

> This is one reason why music experiences or instruction are strongly employed in programs of special education, music therapy, and the like. Music education can be music therapy done early. (p. 322)

One might reasonably ask, 'why wait?'.

This humanistic concept of music education is also supported by Elliott (1995). In his concern to promote a praxial philosophy of music education(1), Elliott is keen to place musical performance as a 'central educational and musical end for all students' (p. 33). Yet this not does prevent him from claiming that:

> Self-growth, self-knowledge, and flow are the central values of MUSIC and, therefore, the central aims of music education. (p. 259)

The concept of *flow* is highlighted by Csikszentmihalyi (1993) when he discusses its relationship with self-growth and how they can combine to promote a higher level of self-esteem for the individual person. He writes:

> Teenagers who report more flow tend to be happier, and they develop academic talents further than teens who are in flow less often. Adults who spend more time in flow work longer, yet are less prone to stress-related illness. . . . Individuals who cannot experience flow, or enjoy only passive and simple activities, end up developing selves that are often in turmoil, riven by frustration and disappointment. (pp. 194-195)

In conclusion, it appears that Bruscia's distinction between music education and music therapy, (emanating from the apparent pre-occupation in education with skill development), may not be clearly supported by either field. As has been noted, there are opportunities within music therapy where the development of musical skills can have a certain therapeutic residue. Likewise, music teachers are also concerned with aspects such as self-growth and the development of essential human values. Within the discussion thus far, however, Bruscia's first assertion may be reasonably contested.

(1) By using the term 'praxial philosophy', Elliott is wanting to place emphasis not only on practical music-making activities (musicing) but also on 'culturally and contextually determined understandings' as a foundation for music education (1995, p. 125).

2 *In music education, the goals are aesthetic or musical first, and functional second; in music therapy, the goals are health-related first, and aesthetic or musical second.*

To an extent, this second assertion by Bruscia appears similar to the first. Once again he is concerned to emphasise the significance of the musical outcome in music education. Yet in this instance the word 'aesthetic' is added and it may be inferred that Bruscia regards 'musical' and 'aesthetic' as synonymous. It would also suggest that within music therapy, aesthetic considerations are secondary at best.

There is an element of boldness in Bruscia's assertion, not least because he applies a hierarchical structure to what he considers to be 'first' or 'second' within the two fields. Furthermore, by claiming that the goals in music education are primarily aesthetic, Bruscia is aligning himself to one side of the debate within music education regarding the prominence of the aesthetic dimension.

While Swanwick (1996) wrote that 'music education is *aesthetic* education' (p. 6), he later appears reluctant to place too much weight on the notion of either-or with regard to this issue: 'There are better places from which to start' (p. 32), he writes in 1999. Ross (1984) discusses the concept of the aesthetic impulse and how this might be the foundation of the aesthetic curriculum. He believes that such a curriculum 'emphasizes the fundamental experience of the sensuous and the primacy of the sense of order' (p. 99). Ross does not believe that aesthetic and artistic development should be considered as separate entities; instead, he maintains that the arts represent a 'sub-division or special instance of aesthetic perception' (p. 26). Perhaps it is almost futile to attempt to differentiate between the two domains as it is hard to imagine one without the other.

Yet Best, for one, would probably disagree. In his book *The Rationality of Feeling* (1992) he is at pains to point out that while there may be some similarities between the aesthetic and the artistic, it is dangerous to consider them as synonymous (pp. 165-180). Part of his motivation for emphasising this point is that it is not in the interest of

arts education to regard them as inextricable. Best maintains that central to the concept of an artistic object (musical or otherwise) is 'the possibility of the expression of a conception of life issues' (p. 173). It is this 'conception of life' which Best believes cannot be found in the distinctly aesthetic experiences of, for example, witnessing the beauty of a sunset. Moreover, he claims that while aesthetic appreciation can have deep personal value, it is neither the same nor as profound as artistic understanding which, he believes, is the purpose of arts education.

Best does not make explicit, however, if artistic understanding *deepens* aesthetic appreciation. Yet such an implication would seem to be there. In light of this emphasis on artistic understanding, one might deduce that Best would situate the aesthetic response within the realm of music therapy, while artistic understanding is more likely to be the prime objective of the music educator. Arguably, this hypothesis does not seem to do justice to the *artistic* quality of the music that is often the outcome of the shared improvisation between therapist and client. For such music may not only be aesthetically satisfying but artistically considered.

Ansdell (2000) suggests that within the arts therapies in general, the tendency to promote the clinical rigour of the therapeutic process in preference to the aesthetic impact of the product, can negate the concept of beauty. Ansdell is keen to differentiate between 'beauty' and 'prettiness' (p. 215) and while the quest for musical beauty would not necessarily be an end in itself for a music therapist, it would be inappropriate not to acknowledge the significance of the aesthetic process as a key part of the therapeutic relationship(1).

Best's view that only a work of art can constitute a 'conception of life' is not unanimously shared. Aigen (1995a) believes that parallels can be drawn between the aesthetic qualities of music and the fundamental processes of life itself. Writing earlier of

(1) In making this claim, Ansdell is referring particularly to the context of Creative Music Therapy rather than to those approaches which primarily deploy a psychodynamic model.

the commonalities between music teaching and music therapy, Duerksen (1967) observes that:

> In music education we speak not only of aesthetic response and excellent performance, but of many other accomplishments. The same is true of music therapy. (p. 95)

Reimer (1989) is keen to remind music educators that while it may be necessary for pupils to learn materials and acquire skills, these should be seen as secondary aims in comparison to the primary objective of acquiring musical aesthetic experiences; this, no less, is the reason for the existence of music. It is likely that Bruscia would concur with this emphasis.

Elliott (1995), however, strongly disagrees with the notion of music education as aesthetic education. Not only does he contend the *aesthetic concept* itself is no longer of significant value but that it diminishes the artistic dimension of music education and seeks to ignore the essential value of music as an art form situated within different social and cultural contexts. Furthermore, Elliott's claim that self-growth and self-knowledge are two of the central aims of music education acts as a reminder of the importance of the individual. Although Bruscia believes that goals in music therapy should primarily be health-related, it does not seem inappropriate to *relate* self-growth and self-knowledge to *health*. Health, as observed earlier, is not simply the absence of illness.

Finally, it is likely that Lee (2003) would not wish the aesthetic dimension to be less prominent in music therapy than it is in music education. As the innovator of Aesthetic Music Therapy (AeMT), Lee places this dimension at the heart of the therapeutic process. He writes:

> The aesthetic content of music therapy has always been considered important although we have yet to fully understand the significance of its impact on the therapeutic alliance. The actualization of the client's aesthetic individuality through music is at the center of AeMT. (p. 22)

In light of the above discussion, the writer has sought to contest Bruscia's second assertion. There does seem to be a body of literature that would respectfully challenge the apparent hierarchy Bruscia affords the aesthetic dimension of music education over the same dimension in music therapy. Thus, there would seem to be a need to clarify the differences between the artistic and aesthetic responses in both fields. In conclusion, however, there would appear to be a greater demand for the pupil in music education to *evince* qualities of artistic sensitivity rather than the client who is attending music therapy.

3 In music education, emphasis is given to the universally shared world of music; in music therapy, emphasis is given to the person's private world of music.

The justification for this third assertion, according to Bruscia, is that the underlying roots may be observed in the broad fields of education and therapy. In education, he claims, the content is general rather than unique to the individual; while in therapy the content *is* unique to the individual. This emphasis given to the universality of music does not accord with Stige's view of the *non-universality* of music (2002) discussed earlier.

By making this assertion, Bruscia also appears to be making at least two assumptions. Firstly, he is implying that the musical content in music education is essentially from another person (or group of people); that this person or group is *other* than the pupil himself or herself. While this may well be the case in the areas of performing and listening, it is certainly not applicable to the area of inventing. The musical content here is entirely the pupil's own even if it may demonstrate influences from the teacher or from other composers. Ultimately, what is being assessed is specific to the individual. Yet even in the area of performing it is not only the musical content that is being learned; rather, the general development of the individual pupil is being encouraged *through* the learning of the musical content. This concept of *learning though* is highlighted in the *National Guidelines: Expressive Arts 5-14* (1992):

> **Learning through** the expressive arts can develop and reinforce skills and concepts acquired in other areas; offer the means for practical and imaginative involvement and

> application; bring learning to life and give a depth of understanding and relevance to the learner. (p. 7)

Thus, while the content may indeed be *general* and *universal*, the rationale for the content is the *general* development of the *individual*. And this may be achieved by the process of *learning through*.

Secondly, Bruscia appears to attribute more value to individual work rather than group work in music therapy. While the therapist will be clinically concerned for the individuality of each group member, the music used may still be general. This notion can apply equally to the deployment of pre-composed music with children (such as the compositions of Nordoff and Robbins) and also to group improvisation. In this latter case, the musical content may be used to facilitate the needs of the group. A recent example of this may be found in the work of Lee and his involvement with the Penderecki String Quartet (2003). While the needs of the individual members of the quartet might not have required clinical intervention, the interrelationships between the members led to the suggestion being made that they should participate in music therapy sessions with Lee. Thus, the quartet whose professional objective was the performance of chamber music, became a quintet (with Lee on the piano) playing improvised music. He writes:

> Chamber music is one of the most intimate forms of musical relationship. Groups often work together closely for many years, there being a sense of "marriage" in their commitment to music and fellow members. Just as with an ongoing group in music therapy, struggles and tensions appear that must be resolved if the group is to flourish and survive. (p. 221)

It is interesting to reflect on Lee's concern that the *group* should flourish and survive; not simply the individuals within the group. This, in the opinion of the writer, is a profound statement which poses many questions and exciting challenges for the future of music therapy. Within this context, music therapy may be considered a useful intervention for *well* people who are in *ill* groups. Furthermore, it seems appropriate to re-direct this hypothesis slightly and suggest that music therapy may be a useful intervention for *well* pupils who are in *ill* or dysfunctional classes. The main point, however, is that in this particular instance, the music being used by Lee and the

Penderecki Quartet was specific to the group rather than to the individuals within the group. The musical content, therefore, was general.

It may be debated that the significance attached to the group concept is in part due to the fact that a group can be seen to represent a microcosm of society (Davies and Richards, 2002). The universal attractiveness of music and the prevalence of musical content within society suggest that it is a powerful and collective medium. If this can be harnessed to the needs of groups within society then it should follow that society itself will benefit. Music therapists need to consider musical content *universally*, to be aware of different musical communities and cultures in addition to the individuals who exist within these cultures.

Depending upon the approach taken by the music therapist, the musical content itself will assume greater or lesser significance. Thus, as Bruscia claims, while in music therapy the musical content is specific to the individual client, it may not hold specific or at least exclusive value for the individual therapist. Yet what appears to be important is the way in which the therapist will *listen* to the musical content. A music teacher, certainly, will listen to the notes. While a music therapist will similarly listen to the notes, there will probably be a keener interest in the 'notes between the notes' (Mac Laverty, 1997, p. 33). In this way, the therapist is listening with clinical intent as to the *why* of the notes in addition to the teacher's concern for the *what* and *how*.

When discussing the phenomenon of music itself, Regelski (1981) believes that it is not the stimulus of music that is most significant but the way in which the human organism experiences the stimulus. He writes:

> It is not the musical score. It is not the source of the sound. Music is the experience of the sound as perceived by the individual person. (p. 30)

Regelski, a music educator, seems unwilling to emphasise the generality of musical content at the expense of the individuality of personal experience: 'The dual content of music education is *music* and the *child*' (p. 34). This view would appear not to equate

with Bruscia's belief that music education is aligned closely to a world of music that is universally shared. For Regelski, it was important that the *experience* was singular even though the *activity* may be shared. There is a sense, therefore, that Bruscia is not making a sufficient distinction between musical activity and musical experience.

To conclude this evaluation of Bruscia's third assertion, it may be argued that a form of re-wording is appropriate. To this end it is intriguing to consider the following adaptation: *The musical content in education begins from a universal basis and gradually moves towards the specific needs and abilities of the individual. Furthermore, where there would appear to be a greater concern for the needs rather than the abilities of a particular individual, the musical content becomes more therapeutically informed.* The writer is suggesting that there may be value in regarding Bruscia's assertion as a continuum rather than as a polarisation. Likewise, it is possible to observe this sense of direction in Swanwick's concern for the content of music to be considered from a metaphorical perspective when he suggests the following process:

1 transform tones into 'tunes', gestures;
2 transform these 'tunes', these gestures into structures;
3 transform these symbolic structures into significant experience. (1999, p. 43)

While 'tunes' and 'gestures' may be considered universal aspects of musical content, 'significant experience' is ultimately a personal phenomenon; that is, it is specific to the individual. Yet Swanwick, like Regelski, is discussing music education rather than music therapy. Once again, however, it seems reasonable to dispute Bruscia's claim on the grounds that while there may be differences between the two fields, such differences are essentially blurred rather than bold. Therefore, it does not seem feasible to discount an element of overlap.

4 In music education, the student-teacher relationship is limited to musical concerns; in music therapy, the client-therapist relationship addresses health concerns that can be addressed through music.

A consideration of this fourth assertion once again requires an appreciation of context. In particular, there are three forms of context to be addressed: personal, musical and contractual.

Firstly, for the most part, a music teacher will be working with a larger group of pupils than a music therapist. It is not uncommon for a music therapist to be dividing his or her time evenly between working with pupils on a one-to-one basis and taking pupils in small groups (normally comprising up to five young people). Inevitably, therefore, the *personal relationship* is different. Pavlicevic (1997) affirms the importance of this relationship when she writes:

> . . . . the therapeutic relationship is considered to be central to the music therapy work: the relationship *is* the therapeutic event, and this event is created, together and concurrently, by therapist and client. (p. 140)

Pavlicevic appears to be suggesting that without a trusting and accepting relationship, therapy cannot take place. The quality of the relationship is paramount to the quality of outcomes. Therefore, within the more intimate context of a music therapy relationship, it is more likely that health concerns can be addressed.

Secondly, in music therapy (depending upon the approach being used by the therapist and the needs and abilities of the pupils involved) there is likely to be a greater emphasis placed on the *musical interrelationship* between the therapist, the client and the music. It may be the case, for example, that a music therapy session will consist purely of music and be devoid of any spoken dialogue. Indeed, it is the music itself that appears to be guiding the two people involved. It is almost as if one's relationship *with* the music is dependent upon one's surrender *to* the music. Alvin (1975) claimed that in individual therapy 'music adds a third person' (p. 143). Yet within music education, according to Swanwick (1996), there is also the important responsibility of the teacher to deepen and broaden the relationship between his or her pupils and the music:

> We should accept that a teacher's role involves a concern for strengthening the relationship between pupils and music. (p. 42)

Notwithstanding this, it seems that the clinical steering of the relationship between the therapist, the client and the music can allow health concerns to be intentionally addressed.

And thirdly, claims Bruscia, the music therapist will not be primarily interested in musical outcomes; while the same may be said of the music teacher there will, to a necessary extent, be a requirement upon the teacher to summatively assess the pupils' musical development. This being the case, the concept of potential failure is a largely inevitable and unwelcome consideration for both the teacher and the pupil. The results *ethic* does not appear in the same way in music therapy. That is not to say the music therapist is not accountable to achieving *success* in an objective manner but this is not quite the same as suggesting that a student has *failed* in music therapy. Thus, the contractual relationship is different. With regard to this latter relationship, Darrow (1996) writes:

> Most music therapists have been trained to administer ongoing assessments of their students' progress; assigning grades, however, is a separate issue. Music therapists often feel uncomfortable assigning grades solely on the basis of musical or academic progress. (p. 29)

In this sense, it is the personal meaning rather than the musical responses that is being assessed. For the music therapist, musical responses do not exist in a vacuum.

Therefore, in considering Bruscia's final assertion, the three forms of relationship - personal, musical and contractual - do appear to be upheld as differences between music education and music therapy. The outcome of these differences in relationship will lead to differences in intent between musical and health concerns.

2.5.5 Training

To a degree, the way in which a music teacher or music therapist practises will be dependent upon how each has been trained. While other factors will clearly influence the nature of one's approach and style, the foundation of training is often the implicit source of ideas and experiences from which the individual person may draw.

Clearly, it is necessary to ensure that music teachers are given sufficient knowledge, skills and experiences at both pre-service and in-service levels to equip them to work competently with pupils who have special needs. And it is here that the issue of overlap between music education and music therapy can become a professional concern (Heine, 1996). Therapists, understandably, are anxious to protect the practice of therapeutic intervention as their own, for that is what they have been trained to do. At the same time, teachers are required to work with the same pupils as therapists; it is entirely right, therefore, that they should have grounds for confidence in their own training as enabling them to work with pupils of all needs and abilities.

While the training routes taken by music teachers and music therapists may have some similarities, they also have fundamental differences (Gascho-White, 1996). While one is working with therapeutic meaning, the other is concerned with educational intent. At this point it can become difficult to distinguish clearly what this involves and it is necessary, therefore, to explore the different approach that a music therapist might use in comparison to a music teacher. And, moving one step further back, it is important to consider how the respective training routes are satisfying the needs of both professions. For in this sense, providers are also consumers.

One particular form of training that would seem relevant to this thesis, is the kind a music therapist might provide for a music teacher (or a group of teachers). And here there are issues of quantity as well as of quality of training. The essence of this debate might be presented as follows: *How much training should a music teacher receive from a music therapist and what form should this training take?* When the focus of work, however, is on the special *educational* needs of pupils, it does not seem unfair to suggest the adaptation of this question to read: *How much training should a music therapist receive from a music teacher and what form should this training take?* According to Pratt (1995), these questions have not been fully addressed in the literature.

It is reasonable to propose that training should consist of the following three areas: knowledge, experience and application. The imparting of knowledge would appear to be

least controversial insofar as it is difficult to stem knowledge. Such knowledge may be gleaned from (among other sources) a book, a video or a website. Knowledge can also come directly from the words of a music therapist through, for example, a case study presentation. Knowledge, therefore, cannot easily be withheld and music therapy has to be transparent both ethically and professionally about *what* it can do and *how* this might be achieved.

Likewise, the opportunity for experience can also be made available. A music teacher may choose to attend music therapy as a client (therefore paying for the service) in order to experience what this form of intervention is like. Similarly, a music teacher might attend a workshop given by a music therapist to experience the *effects* of therapy thus realising how young people might be *affected* by it. In so doing the teacher is, to an extent, acquiring a client perspective. Leite (2002), in her article *Music Therapy for Educators: are we Informing or Training?*, grapples with this issue and concludes that, in her opinion, the most fruitful form of training for the teacher is to be found in this experiential dimension. She writes:

> It is my experience that teachers who participate in experiential music sessions seem to apprehend in a more accurate way the principles of music therapy and later produce assignments that reflect a more flexible and psychologically minded approach to children with disabilities. (p. 15)

Leite believes this is preferable to a more didactic approach and that the experiences gained by the teacher can then be safely incorporated into his or her own approach to teaching. Significantly, according to Leite, this can be equally applied to the well-being of pupils who do not have a particular learning difficulty or form of disability. Although Leite does not always distinguish between music teachers and general teachers, she appears supportive in principle of the transition from personal experience to professional application.

The concept of application appears to be most prevalent when the training a teacher receives is on-site rather than off-site. And it is here that the music therapist may be

working as a consultant. For some time in the USA, there has been an increasing demand for music therapists to work not only in a *direct service* with clients but also in a *consult service* with, for example, teachers. There are valid reasons for this, certainly educational and perhaps economic (Michel, 1985). Steele (1977) discusses this form of working relationship in her paper *Directive Teaching and the Music Therapist as Consultant.* This was based on a five-year programme in which a music therapist was selected to work in a consultative capacity with members of the teaching staff and, in so doing, assisted staff members to devise alternative teaching strategies for students with behavioural difficulties. She writes:

> The consultant did not tell the teachers what to teach but together they sought to marshal whatever resources were available to help make the learning experience as productive as possible. (p. 19)

Steele seems to be implying here a sense of companionship between the different professionals to the extent that teachers were also acting as consultants to the music therapist.

Johnson (1996) outlines the different contexts in which the music therapist may operate as a consultant: these include consulting to facilitate inclusion, music education, music performance and also the need to consult with non-music education staff. Yet, as noted earlier, while the therapist may provide consultative help for the teacher, it can be argued that because many of the issues are educational in nature, the therapist should also be trained in the principles of music education. Within the context of this debate, training largely seems to be uni-directional. Johnson, however, acknowledges the value of a training qualification in teaching for a music therapist by claiming:

> Dual certification (such as a teaching license in music education) is an additional asset in the area of inclusion and gives the music therapist credibility in dealing with special education as well as regular education personnel. (p. 61)

More recently, Chester, Holmberg, Lawrence and Thurmond (1999) planned and implemented a Programme-Based Consultative Music Therapy Model for public schools in

Texas. The aims of this were to allow more students to receive music therapy provision and for teachers themselves to adopt music therapist-generated strategies. It also sought to encourage greater collaboration across the disciplines and, not least, to maximise the time spent by the therapist in the classrooms. Emphasis was placed on each pupil's Individual Education Plan and the combining of the direct service with the consult service. The authors conclude that the programme was not only a qualitative success but resulted in 'four music therapists . . . [serving] 55 teachers with 72 classes on 29 campuses containing 424 students' (p 86). It is worth noting that this form of training for teachers was both on-site and off-site.

The process of consultation appears to suggest an acceptance of at least one shared objective between therapist and teacher. The fact that the therapist is encouraging (by means of training) the teacher to work along therapeutic lines, implies that educational aims are not being compromised. Indeed, it is likely that the teacher can only enhance the quality of musical involvement by *bringing to* the encounter a strong educational foundation that has continued to evolve through systematic practice and experience.

2.5.6 Conclusion

In light of this discussion, it seems reasonable to conclude that music teachers would benefit from a more sustained mode of training with regard to music therapy practices – from the acquisition of knowledge to the process of application. Leite's desire to place emphasis on experiential opportunities would appear to represent an appropriate foundation for other activities. According to Welch, Ockleford and Zimmermann (2001), such training arrangements are lacking and there is an urgent need to:

> . . . . set up professional development courses in music education for specialists and non-specialists with such pupils [severe or profound and multiple learning difficulties] (in line with a Teacher Training consultation proposal in 1998). (p. 54)

While the three authors are referring to practices in England, their findings would also appear to be in line with the recommendations made in the HMI report (1996) in Scotland for joint training opportunities to be made available for teachers and school-based

therapists. Furthermore, it may well be argued that music therapists are not receiving sufficient training in educational issues to allow them to work most effectively in the school setting. At the very least, music therapists need to be aware of inclusive procedures and the continuously evolving practices of music education.

And finally, the above review of literature suggests that there can be a tendency for music therapists to hold back or at least avoid providing explicit assistance to music teachers about therapeutic techniques. As Leite (2002) writes:

> Are we providing them [the teachers] with basic information about our work or are we unintentionally encouraging a form of intervention for which they are not sufficiently trained?

The needs of teachers to successfully meet the needs of pupils suggest that it would be highly appropriate to *intentionally* encourage a form of intervention by means of *more appropriate* training. To this end, an educational dimension to music therapy would seem to be a logical, professional and ethical development that requires to be formalised and implemented.

According to the literature, therefore, a degree of theoretical interdependence between music therapy and music education has links with good practice and could therefore lead to the realisation of practical outcomes that are both attainable and highly desirable. Thus, within the literature reviewed there is evidence of a motivation for theoretical interdependence between the two professions.

CHAPTER 3 METHODOLOGY, DESIGN AND METHODS

3.1 Methodology and Subsidiary Research Question

Ansdell and Pavlicevic (2006) define the process of methodology as 'the overall approach (paradigm) to research, which has roots in a research tradition or philosophy' (p. 97). With regard to this thesis, the writer considers it necessary to outline the particular methodology chosen and how it has been deployed throughout the investigation as a whole.

In chapter 1.3.1 the theoretical emphasis of this thesis was outlined, thus giving a basis to the decision that most of this investigation should be located in the review of literature. While this involved a conceptual analysis of the relationship between music therapy and music education, a particular focus was applied to the potential need for theoretical interdependence between these two fields. The review of literature, therefore, was undertaken within the frame of a *primary research question.* This was presented as follows:

Within the literature selected for review, is there a motivation for theoretical interdependence between music therapy and music education?

Thus, to a large degree, the chosen methodology for this thesis is a qualitative analysis of the review of literature. The foregoing review explored the opinions of authors and practitioners from both fields. This allowed the writer to acquire a sense of how people *felt* through what they *wrote* regarding the similarities and differences between music therapy and music education. Such feelings were articulated from a range of theoretical standpoints. At the culmination of this review, the writer concluded that the literature provided reasonable justification for claiming that there was indeed a motivation for theoretical interdependence between music therapy and music education.

A further dimension to this investigation is the inclusion of findings pertaining to the interviews of eleven participants. This represents a small empirical study and seeks to inform the analytical conclusions of the review of literature. The inclusion of this form of data collection is not intended to represent a parallel or equal weighting to that attributed to the literature review. As a result, the writer proposes the following *subsidiary research question* to accompany the primary research question above:

In light of the perceived motivation for theoretical interdependence between music therapy and music education, what are the professional concerns and aspirations relating to an educational dimension to music therapy?

From a methodological perspective, there is a degree of quantitative analysis to the responses of participants as consideration is given to the numerical prominence of different views expressed. The findings of these views are then explored qualitatively by reflecting on the feelings, motivations and impulses that underpin these views (Maykut and Morehouse, 1994). This interaction of quantitative and qualitative perspectives, according to Kvale (1996), is important to the practice of research and helps to avoid an either-or stance being adopted. Furthermore, the complementing of these two approaches facilitates the process of transparency.

Aigen (1995) suggests that as music therapy is a service profession, then the research music therapists undertake should be 'oriented toward enhancing the lives of our clients through illuminating the nature of their experience and trying to identify factors which contributed to their positive experience' (p. 301). In the opinion of the writer, the combining of these methodologies with regard to the empirical data is an appropriate way to 'identify factors' that will enhance the lives of young people with special needs through the form of interaction deployed by music teachers and music therapists.

3.2 Design

Wheeler (1995) defines the process of design as 'the way that a quantitative or qualitative research study is structured in order to answer the questions posed' (p. 554). The essential focus of this investigation is concerned with people. Broadly speaking, the people involved may be arranged into two populations of providers and consumers. The providers are music therapists and music educators(1). The consumers are the clients who are receiving music therapy, the pupils who are receivers of music education in schools and also the students who are training to become either music therapists or music teachers. To a large extent, the empirical dimension to this thesis is based on an exploration of people's opinions about what they do, and how they may have to alter and adapt what they do in light of new developments. The design of this research, therefore, must be structured in such a way that can explore the opinions of the chosen providers in the most transparent way.

The writer considered three forms of collecting data that could assist this exploration of opinions. These were as follows:

- questionnaires;
- observation of practice;
- interviews.

One advantage of questionnaires is that they help yield a considerable body of data. This could be achieved, for example, by sending a series of questions to members of the Association of Professional Music Therapists (APMT) and also to members of the National Association of Music Education (NAME). The writer felt, however, that the questions would require an essential discursive element that could be facilitated more

(1) the word 'educators' rather than 'teachers' is used here as a means of incorporating music teachers, visiting music specialists and heads of music education training courses within a single category of music educators.

easily through verbal conversation of ideas rather than written presentation of responses. On this basis, the use of questionnaires was discounted.

One advantage of observation of practice is that it allows the writer the opportunity to see and hear - at first hand - the techniques, approaches and forms of interaction deployed by music therapists and music educators. This could be followed by a discussion with the respective music educator or music therapist. Where appropriate, discussions could also take place with those who had been receiving music education or music therapy. However, while the opportunity to observe practice would be insightful, there would be an inevitable focus on current rather than future methodological principles in action. This investigation is concerned with the possibility of new theoretical frameworks (rather than a discussion of existing frameworks) and their influence upon future working contexts. Furthermore, the practical implementation of observing different forms of intervention would be difficult to organise and, in cases of clinical intervention such as individual music therapy, ethically inappropriate. This latter consideration would apply to video analysis of material as well as to live observation of work. For these reasons, therefore, observation of practice was discounted.

One advantage of interviews is that they can allow for the creativity and spontaneity that inevitably arise when two or more people *wrestle* with an idea. The opportunity to discuss new theoretical and practical issues with people who, potentially, could be responsible for their implementation would likely yield significant and rich data. The questions were such that they needed to be discussed *with* rather than (merely) answered *by* those involved.

Drever (1995) promotes the use of semi-structured interviews as a helpful midway point between the process of an interviewer reading out a set of questions with a selection of answers from which the interviewee must choose, and the context of an entirely non-directive style of discussion between interviewer and interviewee. As such, the semi-structured interview allows the researcher to plan the interview in advance by preparing an interview schedule with a series of carefully selected questions. From this

schedule, a flow of discussion can evolve between both parties that is contained within a clear structure. The sensitive use of prompts and probes by the interviewer ensures that the schedule is adhered to, yet sufficiently flexible to facilitate moments when the interviewer wishes to explore an issue in greater depth or gently challenge or cajole. This may be especially relevant when there is an emphasis upon open rather than closed questions.

A potential disadvantage of interviews is expressed by Kelman (1972) when he warns that subjects may be coerced into adopting the favoured stance of the interviewer himself or herself. Similarly, Ansdell and Pavlicevic (2006) state that there is a danger of bias emanating from 'leading questions' (p. 190). Yet these same authors promote the use of semi-structured interviews as promoting a form of conversation that is 'an *equal dialogue*' (2006, p. 190). Likewise, Kvale (1996) suggests that a qualitative research interview is 'literally an *inter view*, an inter change of views between two persons conversing about a theme of mutual interest' (p. 2). Kvale (1996) also presents the different metaphorical stances that the interviewer may take as either a *miner* or a *traveller.* Whereas the miner approach to interviewing considers knowledge as 'buried metal and the interviewer is a miner who unearths the valuable metal' (p. 3), the traveller approach is concerned with the interview as a 'journey' in which the interviewer is 'wandering together with' each of the participants (p. 4).

As well as being a traveller, the interviewer is also a learner. Therefore, by taking this perspective, it is less likely that Kelman's concern of coercion of the interviewee will be manifest. This point is sensitively made by Spradley (1979) when he describes the role of the interviewer in the following way:

> I want to understand the world from your point of view. I want to know what you know in the way you know it. I want to understand the meaning of your experience, to walk in your shoes, to feel things as you feel them, to explain things as you explain them. Will you become my teacher and help me understand? (p. 34)

For these reasons, therefore, the design chosen to answer the questions posed in this investigation most appropriately is the implementation of semi-structured interviews. The writer himself is the research instrument. Aigen (1995) writes that the *researcher-as-instrument* allows for the 'open-mindedness, insight, and thoroughness of the *researcher* that ensures the production of interesting and useful findings' (p. 296). The specific methods deployed as part of this process are now presented.

3.3 Methods

According to McGuire (1995), the articulation of methods deployed in a research investigation should indicate a 'brief, yet detailed, description of how the study was carried out' (p. 269). This requires a more specific explanation of the devices and techniques used to gather, organise and present the respective data. In light of the decision to use semi-structured interviews as the basis for the research design, the identification of interview participants could now begin.

3.3.1 Choice of Category of Participants

From the outset of this process the writer sought to identify certain categories of people - and thereby professions - that should be represented in order to respect the diverse yet related areas underpinning the research investigation. The following categories were initially chosen:

- music therapists;
- music teachers;
- heads of music therapy training courses;
- heads of music education training courses;
- students of music therapy training courses;
- students of music education training courses.

After some consideration, the writer felt that the interviewing of students from music therapy and music education training courses would be difficult to arrange. Furthermore,

by interviewing recently qualified music therapists and music teachers - as well as people with many years' experience - there was a sense that, to an extent, the student *voice* was being heard and that those involved could relate their everyday working responsibilities to their individual training background.

The writer also felt that the inclusion of sub-categories was required under the main headings of music therapy and music education. Music therapy, therefore, should represent people working in adult mental health settings as well as those whose practice was in the field of learning disability with young people. Within music education, it was important to include individuals from the discrete areas of secondary music teaching, primary music teaching and music education within the special needs' sector. The choice of categories and sub-categories is now presented as follows:

- **MUSIC THERAPY**

  music therapy within the area of learning disability (including children and adults);

  music therapy within the area of adult mental health;

  music therapy within a training course.

- **MUSIC EDUCATION**

  music education within the secondary school sector;

  music education within the primary school sector;

  music education within the special needs' sector;

  music education within a training course.

3.3.2 Piloting of Interviews

Before embarking on the process of formally writing to potential interviewees, a decision was taken to pilot a number of interviews. This would allow the writer to acquire a *feel* for the interview process and to become accustomed to engaging in this form of semi-structured debate. It would also encourage those involved in the piloting process to comment on the suitability of the questions presented as well as the nature of this kind of

encounter. In their opinion, for example, was this the best choice of questions to use as the means of acquiring the essential information (data) that was being sought?

Drever (1995) presents a range of contexts within which semi-structured interviews may be held, such as telephone interviews and group interviews. For the piloting process, the writer chose to interview people in a face-to-face setting. There were two reasons for this: firstly, it allowed the writer to notice non-verbal cues such as body language and gesture. As Kvale (1996) writes:

> The lived interview situation, with the interviewee's voice and facial and bodily expressions accompanying the statements, provides a richer access to the subjects' meanings than the transcribed texts will later. (p. 129)

Secondly, this form of interview can promote a mood of companionship that may favourably assist the subsequent dialogue and debate.

The writer then wrote to three people whom he considered particularly appropriate for the piloting process. Each person agreed to participate and this was followed by the submission of a list of questions - the interview schedule - that would form the basis of the semi-structured interview. The schedule consisted of twelve questions and had been approved earlier by one of the writer's supervisors (see appendix 1). A range of open, closed and multiple questions comprised this list as can be seen below:

- two open questions (1 and 2);
- four closed questions (5, 6, 7 and 12);
- two closed questions leading to an open discussion of the responses (3 and 4);
- four multiple questions which consisted of closed questions that represented a form of probing with regard to the main point being discussed (8, 9, 10 and 11).

The writer felt it important to provide the interviewees with the questions in advance so that they might have time to consider the various issues involved. Drever (1995) cautions against this as it may lead to each interviewee preparing too carefully for the

meeting, sometimes to the point of writing down the responses to each of the questions in order that they might be simply read out during the interview. In the opinion of the writer, however, due to the inclusion of questions that were concerned with potential future directions and professional aspirations, each participant should be provided with the questions as a *stimulus* for initial thinking rather than as a requirement for detailed and finite writing. Furthermore, the nature of the semi-structured interview would necessitate discussion that would inevitably contain a degree of spontaneity.

The particular format of the pilot interviews was then considered. Due to the semi-structured arrangement of the interviews, it was suggested that one of the participants should be interviewed on a one-to-one basis and that the other two participants be interviewed simultaneously. This latter arrangement seemed appropriate as the two people concerned worked closely together and the notion of what would amount to a tripartite discussion added a new dimension to the interview process. The rationale for these two forms of interview was that it would inform the writer as to what might be the most productive format to adopt when gathering data from later interviews.

The personnel for these two pilot interviews was as follows:

- a woman with many years' experience as a visiting primary music specialist who was now working as a lecturer in a college of higher education; her main remit was to provide future teachers (in the primary school sector) with the skills, experiences and resources necessary to teach music;

- two women who were working as music specialists in a large special school; each had a keen interest in music therapy; one had recently been appointed to this position while the other was shortly to be retiring.

The interviews were held in the respective places of work of the three participants. A Sony Professional Walkman cassette recorder was used for the taping of interviews. Each of the participants was known to the writer and this helped to promote a sense of flow as

well as a constructive degree of informality to the ensuing discussion. While the writer adhered to the list of questions provided, the importance of listening was central to the interview process. The deployment of 'empathic active listening' (Kvale, 1996,) was found to be helpful as a means of absorbing the 'nuances and layers of meaning' that accompanied the spoken word (p. 135). This was the basis for the subsequent probing of responses given.

Following the interviews, it was felt by the writer and the three interviewees that, in general, this had been a fruitful and revealing exercise. The questions were considered to be appropriate and drew from the participants the kinds of information and data that were being sought. It was suggested that, due to the different contexts in which music therapists and music teachers practise, it would be interesting to note the number of people with whom they worked each week. In light of this, the number of questions comprising the interview schedule changed from twelve to thirteen. No other alterations were made with regard to the interview questions. The opportunity for participants to further contribute at the conclusion of the 'official' interview was felt to be desirable.

The process of listening back to the tapes and noting comments was then undertaken. A verbatim transcript was not thought to be necessary at this stage as the main purpose was for the writer to acquire familiarisation with the interview procedure and to consider the significance of the questions in relation to the information being required. Two concerns, however, were noticed by the writer when listening to the interview recordings. Firstly, he required to be more dynamic with regard to the participants' responses to closed questions. Thus, a greater degree of probing and prompting was needed in order to explore the *meaning* of the responses (Ansdell and Pavlicevic, 2006). The incorporating of brief questions that may lead to long answers, as suggested by Kvale (1996), would likely help with this process. The need to find an appropriate balance between respecting and challenging the responses of the interviewees was something that the writer had to consider more carefully.

Secondly, the writer noticed that the interview with two people simultaneously was less successful. The main reason for this was that the discussion proved more difficult to manage as there was a tendency to lose focus of the original question and explore issues that were not so directly related; in short, it became over-discursive. Furthermore, the process of listening back to the recording was often demanding as the enthusiasm of those involved frequently resulted in more than one person speaking at a time.

It was therefore decided to proceed with the slightly revised interview schedule of thirteen questions of which twelve had been used in the pilot interviews. Time for further comments and discussion would be offered at the conclusion of the interview schedule. The decision was also taken to contain all the interviews within a one-to-one context between the writer and the participant.

3.3.3 Choice of Individual Participants

The criteria for deciding which particular people should be involved in the interview process were based on the following two considerations:

- Who, in the opinion of the writer, might be *appropriate* to be involved?
- Who, in the opinion of the writer, might be *willing* to be involved?

A degree of commitment was an important factor as each participant would need to invest a reasonable amount of time as a condition for being involved in the project; time spent preparing for the interview as well as taking part in the interview itself.

Due to the professional experience of the writer, he was in the fortunate position of having a personal acquaintance with the majority of people whom he decided to approach. It was felt, too, that this was a positive contributory element to the relationship between the interviewer and each individual interviewee. A sense of companionship - as suggested by Kvale (1996) through the use of the *traveller* metaphor - within a formal structure would hopefully encourage a rich and productive quality of discourse.

3.3.4 Procedure for Approaching Prospective Interviewees

As a result of identifying a range of people whom the writer believed would be both appropriate and willing to be involved, a letter was devised as a means of *invitation to* the project as well as an *explanation of* the project (see appendix 2). The letter stated that if the potential participant wished to be involved, the writer would then make contact to discuss in more detail the various procedures and format for the interview itself. This form of contact was arranged either as a meeting or a telephone conversation. This was the opportunity for the writer to confirm ethical procedures which included explaining to participants that while each interview was to be recorded on cassette tape, protection of identity would be maintained at all times. A reply slip was attached to the letter which indicated a preferred date for return (see appendix 3).

3.3.5 Sample Group of Participants

A total of seventeen letters were distributed to the following people:

- four music therapists;
- three course directors of music therapy training courses;
- four music teachers in secondary schools;
- four visiting music specialists who were working partly in primary schools and partly in special schools;
- two course directors of music education training courses.

The responses from these letters were as follows:

- all of the music therapists replied and agreed to participate;
- one of the course directors of music therapy training courses replied and agreed to participate;
- three of the music teachers in secondary schools replied and agreed to participate;
- three of the visiting music specialists replied and agreed to participate;
- two of the course directors of music education training courses replied and one agreed to participate.

Of the seventeen people approached, therefore, thirteen replied; of these only one declined to participate. This left a potential sample group of twelve people. One person, however, (a visiting music specialist) later had to withdraw due to a change in personal circumstances.

A final sample group of eleven people was finally confirmed and each participant can now be categorised as follows under the general headings of music therapists and music educators:

MUSIC THERAPISTS

- **Music Therapist (MTh1)**
  - has worked mainly in the area of community learning disability (and some experience in mental health) with both adults and children;

- **Music Therapist (MTh2)**
  - has worked mainly in the area of learning disability with children (and some experience with adults); this person is also a qualified music teacher;

- **Music Therapist (MTh3)**
  - has worked mainly in the area of learning disability (and some experience in mental health) with both adults and children;

- **Music Therapist (MTh4)**
  - has worked mainly in the area of adult mental health (and some experience in learning disability with both adults and children);

- **Course Director of a Music Therapy Training course (MTh5)**
  - worked as a music teacher before training as a music therapist;

MUSIC EDUCATORS

- **Secondary School Music Teacher (MEd1)**
  - relatively recently qualified, has an active interest in and knowledge of music therapy;

- **Secondary School Music Teacher (MEd2)**
  - very recently qualified, has a knowledge of music therapy and previously had an active interest in music therapy;

- **Secondary School Music Teacher (MEd3)**
  - a very experienced teacher who has had an ongoing interest in music therapy;

- **Visiting Music Specialist (MEd4)**
  - recently qualified, and is working in both the primary and special needs' sectors; has an active interest in and knowledge of music therapy;

- **Visiting Music Specialist (MEd5)**
  - recently qualified, and is working in both the primary and special needs' sectors; has an active interest in and knowledge of music therapy;

- **Course Director of an Undergraduate Music Education Training Course (MEd6)**
  - has an active interest in and knowledge of music therapy.

The above sample group represents the diversity of professional contexts pertaining to this investigation. It also represents a cross-section of experienced practitioners with those who are relatively new to their chosen profession. Each person is a provider of either therapy or education; it is also important to note that each person has been a consumer of education.

3.3.6 The Interview Process

The interviews were held either in the place of work of the writer or of the respective participant. The duration of each interview ranged between 50 and 90 minutes. As with the two pilot interviews, a Sony Professional Walkman was used to record the discussions. Upon completion of the interview schedule, each participant was given the opportunity to add further thoughts or comments if he or she so wished.

3.3.7 The Procedures for Data Analysis

Upon the advice of his supervisors, the writer chose to adopt the following procedures as a means of analysing the data accumulated on the eleven audio cassettes:

1 Each interview was listened to in its entirety. No notes were taken at this stage and this allowed the writer to acquire a sense of the whole discussion in a non-participatory manner.

2 Each interview was listened to again. This time the writer adopted a 'note-and-quote' method in which key points were written down in the form of a quotation from one of the participants (Ansdell and Pavlicevic, 2006, p. 194).

3 Each interview was transcribed in a written format. Four were transcribed by the writer and the remaining seven by a professional secretary. The transcripts were made in a verbatim format which allowed the writer to notice the 'pauses, emphases in intonation, and emotional expressions' in addition to the words themselves (Kvale, 1996, p. 170). An example of a written transcript can be found in appendix 4.

4 The writer carefully read each of the transcripts to familiarise himself with the written version and to check that the 'note-and-quote' points accurately corresponded to the full written transcript.

5 The process of coding and counting was then undertaken (Drever 1995). By using different coloured highlighter pens, the writer identified specific responses to each individual question (coding) and then noted how many times similar responses occurred (counting).

6 The result of the coding and counting process led to a decontextualisation of the material from the eleven interview transcripts. Essentially this acts as a form of data reduction (Ansdell and Pavlicevic, 2006). This allowed the material to be regrouped into higher level categories. In effect, this re-categorisation was observed in the collapsing of the thirteen questions comprising the interview schedule into the following seven questions/categories:

(i) *What are the kinds of aims that a music therapist would most frequently work towards?*

(ii) *What are the kinds of aims that a music teacher would most frequently work towards?*

(iii) *What are the areas of commonality between the two professions?*

(iv) *What are the areas of difference between the two professions?*

(v) *How clearly can clinical needs be distinguished from special educational needs?*

(vi) *Due to an increasing emphasis on policies of inclusion, it would seem essential that both future and current teachers of music are given training as how best to work with pupils who have special educational needs. What form should this training take and who might provide it?*

(vii) *Would music therapists and music teachers benefit from working more closely together? In what ways might this happen? What views are held, for example, with regard to the music therapist acting in a consultative capacity with music teachers who are working with pupils who have special needs?*(1)

7 The findings could now be presented. This entailed analysing the material from a qualitative perspective and noting the 'values [that] are inherent in and central to [the] investigation' (Wheeler, 1995, p. 565). To assure confirmability of the qualitative findings, however, a quantitative presentation was also made in which the prevalence of specific views could be observed.

The quantitative and qualitative findings of this empirical study are presented in the following chapter.

(1) As can be seen, question (vii) is a multiple question and, as such, represents the over-arching category of collaborative practice. The diversity of responses given, however, appeared conducive to presenting the category in this way.

CHAPTER 4 PRESENTATION OF FINDINGS

A summary of responses made to the seven questions presented in chapter 3.3.6 is now presented. This is reported first in a quantitative format in which the different statements that were made - and the number of times in which they were made - are given. These are categorised according to: a) the responses of the six music educators; b) the responses of the five music therapists, and c) the combined responses of the eleven people. Percentages have been used in the presentation of these findings. A breakdown of the relationship between the number of people responding and the comparative percentage is as follows:

MUSIC EDUCATORS

One person = 16.6%
Two people = 33.3%
Three people = 50%
Four people = 66.6%
Five people = 83.3%
Six people = 100%

MUSIC THERAPISTS

One person = 20%
Two people = 40%
Three people = 60%
Four people = 80%
Five people = 100%

MUSIC EDUCATORS AND MUSIC THERAPISTS

One person = 9%
Two people = 18.2%
Three people = 27.3%
Four people = 36.4%
Five people = 45.5%
Six people = 54.5%
Seven people = 63.6%
Eight people = 72.3%
Nine people = 81.2%
Ten people = 90.1%
Eleven people = 100%

Following this quantitative presentation, a brief qualitative analysis of the responses to each question will be provided. This will focus on the essence of the views being expressed and will entail careful consideration of the various perspectives held by people in light of their professional responsibilities and experiences.

The findings for each of the seven questions are now presented:

(i) *What are the kinds of aims that a music therapist would most frequently work towards?*

RESPONSES FROM MUSIC EDUCATORS	%
Meeting the needs of the individual	33.3%
Development of communication skills	33.3%
Development of physical abilities and co-ordination	33.3%
Facilitation of creativity through music	16.6%
Facilitation of self-expression through music	16.6%
Improvement of self-discipline	16.6%
Development of self-confidence through skill-based activities	16.6%
Encouragement of feeling part of a group through music making	16.6%
Acquisition of self-achievement through participation in group activities	16.6%
Providing a form of relief or escapism for pupils who have profound disabilities	16.6%

RESPONSES FROM MUSIC THERAPISTS	%
Resolution of personal/psychological/emotional issues	80%
Encouragement of increased tolerance	80%
Facilitation of self-expression through music	80%
Development of interaction	80%
Development of communication skills	60%
Development of initiative	40%
Development of self-awareness	40%
Meeting the needs of the individual	20%
Development of concentration span	20%
Development of listening skills	20%
Development of musical skills through participation	20%
Encouragement of a positive attitude towards learning	20%
Encouragement of play	20%
Encouragement of spontaneity	20%
Removing obstacles	20%
Supporting people if they are very ill	20%
Improving quality of life	20%

COMBINED RESPONSES FROM MUSIC EDUCATORS AND MUSIC THERAPISTS	%
Development of communication skills	45.5%
Facilitation of self-expression through music	45.5%
Encouragement of increased tolerance	36.4%
Resolution of personal/psychological/emotional issues	36.4%
Development of interaction	36.4%
Meeting the needs of the individual	27.3%
Development of physical abilities and co-ordination	18.2%
Development of initiative	18.2%
Development of self-awareness	18.2%
Improvement of self-discipline	9%
Development of self-confidence through skill-based activities	9%
Encouragement of feeling part of a group through music making	9%
Acquisition of self-achievement through participation in group activities	9%
Development of concentration span	9%
Development of listening skills	9%
Development of musical skills through participation	9%
Encouragement of a positive attitude towards learning	9%
Encouragement of play	9%
Encouragement of spontaneity	9%
Removing obstacles	9%
Supporting people if they are very ill	9%
Improving quality of life	9%
Providing a form of relief or escapism for pupils who have profound disabilities	9%

The most frequent responses to this question were the development of communication skills and the facilitation of self-expression through music. These were each alluded to on five occasions. Contributory factors to these responses included the affective, abstract and non-verbal qualities of musical exchange in therapy. Aims could be worked towards through the music itself and did not necessarily require verbal affirmation. One therapist who worked with adults with learning disabilities commented:

> I don't actually work with anybody who would like to talk about what they do, or talk about what happened. That's not relevant to my work at present. (MTh3)

Conversely, another therapist working in the field of adult psychiatry claimed that aims would often evolve as a result of verbal comments made by the client *in advance* of musical interaction:

> With adult clients, I have a relationship with them that is similar to a counselling relationship in which they may make specific reference to things that have happened and we can explore these in the music. (MTh4)

On four occasions the personal component of music therapy was highlighted as a significant aspect of the work; music therapists, therefore, would often seek to assist psychological or emotional deficiencies that people might have. This included working with aspects of aggression, exploration and resolution.

The opinion that aims in music therapy should be determined by the needs of the individual client was stated three times. Upon this basis, therefore, the therapist is required to take an approach that is largely non-directive. Only when the needs are known can the therapist plan and implement a programme suitably tailored to the individual. This essential focus on needs implies that the individual client is restricted in some way from being a fully functioning person. This view was confirmed by statements such as 'my aim is to support people if they are very ill' (MTh4) and 'therapy is about removing obstacles' (MTh2).

A broad range of life skills that might be acquired through the intervention of music therapy was highlighted. In particular, this included the development of increased tolerance and working successfully in a group context. In other ways, learning could be facilitated through the development of concentration, listening, and encouraging a greater sense of self-confidence, self-discipline and initiative. One therapist felt that music therapy was partly concerned with turning a negative attitude that a young person may hold towards learning - e.g. for a pupil with behavioural difficulties - into a more positive one (MTh2).

Throughout these responses, there was a general sense that music therapy was something that people enjoyed and that out of such enjoyment aims could be positively implemented. Through therapeutic activities in music, for example, there were distinct opportunities to encourage aspects of play and spontaneity; one therapist spoke of the 'emotional release experienced through the physical act of playing' (MTh1). One educator noted that for pupils with profound disabilities, music therapy could provide 'a form of relief or escapism' (MEd5).

In summary, twenty-three different responses were presented; ten different responses were made by music educators while seventeen were given by music therapists. The inclusion of the development of communication skills and self-expression featured in both sets of responses. It is interesting to observe, however, that the emphasis placed on the psychological component in music therapy was not explicitly mentioned by the music educators.

(ii) *What are the kinds of aims that a music teacher would most frequently work towards?*

RESPONSES FROM MUSIC EDUCATORS	%
Provision of enjoyable experiences overall	50%
Provision of broad musical experiences	50%
Development of social interaction	50%
Development of teamwork	50%
Development of personal attributes	33.3%
Acquisition of a sense of achievement in a finished product	33.3%
Development of confidence	16.6%
Development of musical knowledge	16.6%
Development of musical skills	16.6%
Development of the aesthetic response	16.6%
Development of listening skills	16.6%
Development of group performance skills	16.6%
Development of children's tastes in music	16.6%
Inclusion of as many pupils as possible in musical activities	16.6%
Provision of opportunities for differentiation	16.6%
Provision of opportunities for stretching pupils as far as they can go	16.6%
Encouragement of those pupils who are musically able	16.6%
Facilitation of academic progression	16.6%
Encouragement of self-discipline	16.6%
Encouragement of creativity	16.6%
Encouragement of self-expression	16.6%
Encouragement of expression of ideas	16.6%
Encouragement of imagination	16.6%
Opportunities for learning about music	16.6%
Opportunities for learning through music	16.6%
Opportunities for learning about life	16.6%
Opportunities for musical participation	16.6%
Opportunities for pupils to strive towards acquisition of perfection	16.6%
Opportunities for experiencing variety	16.6%
Provision of general support for class teachers	16.6%
Means of ensuring that all aspects of the curriculum are covered	16.6%

RESPONSES FROM MUSIC THERAPISTS	%
Development of musical skills	100%
Development of personal attributes	40%
Development of musical knowledge	20%
Development of listening skills	20%
Opportunities for acquiring a progressive overview of music	20%
Opportunities for acquiring a finished product	20%

COMBINED RESPONSES FROM MUSIC EDUCATORS AND MUSIC THERAPISTS	%
Development of musical skills	54.5%
Development of personal attributes	36.4%
Provision of enjoyable experiences overall	27.3%
Provision of broad musical experiences	27.3%
Development of social interaction	27.3%
Development of teamwork	27.3%
Development of musical knowledge	18.2%
Development of listening skills	18.2%
Acquisition of a sense of achievement in a finished product	18.2%
Opportunities for acquiring a finished product	9%
Opportunities for acquiring a progressive overview of music	9%
Development of confidence	9%
Development of the aesthetic response	9%
Development of group performance skills	9%
Development of children's tastes in music	9%
Inclusion of as many pupils as possible in musical activities	9%
Provision of opportunities for differentiation	9%
Provision of opportunities for stretching pupils as far as they can go	9%
Encouragement of those pupils who are musically able	9%
Facilitation of academic progression	9%
Encouragement of self-discipline	9%
Encouragement of creativity	9%
Encouragement of self-expression	9%
Encouragement of expression of ideas	9%
Encouragement of imagination	9%
Opportunities for learning about music	9%
Opportunities for learning through music	9%
Opportunities for learning about life	9%
Opportunities for musical participation	9%
Opportunities for pupils to strive towards acquisition of perfection	9%
Opportunities for experiencing variety	9%
Provision of general support for class teachers	9%
Means of ensuring that all aspects of the curriculum are covered	9%

The development of musical skills was most frequently highlighted as an aim that music teachers would work towards. While this was referred to by six people, it is interesting to note that five of these people were music therapists - i.e. all of the music therapists interviewed. Broadly speaking, while the view held by music therapists was that aims were primarily musical, for music educators there was a stronger sense that the taking part in music could fulfil wider objectives for each pupil. The development of social interaction, for example, was highlighted by three out of the six music educators. Thus, there was a necessary balance to be achieved between learning *about* music and learning *through* music. As one educator commented:

> Music is not just a subject in its own right within a school. It's a very important tool for teaching children teamwork, self-discipline, encouraging them to be creative and is a means of expressing themselves in a way which is not necessarily dependent on words. (MEd3)

Within both sets of participants, the view was expressed that music education should address the *whole* person and, notwithstanding the level of skill held by each pupil, the experience should be enjoyable as well as educational. Music education should be 'personal developmental' (MEd6). Furthermore, the extra-curricular opportunities provided by many music departments allowed pupils unique access to working alongside others in creative and imaginative activities.

A particular notion conveyed was - that through music education - pupils had the opportunity to *be* themselves and to *express* themselves. There was a feeling that for some pupils the music department represented a kind of refuge and a place of self-discovery. One educator felt that this was more important than the passing of examinations or the attaining of grades. Her comment that 'this is the *feelgood* department' encapsulated her view of how pupils might perceive a music department within a school (MEd1). This sentiment was shared by a music therapist who said that the emphasis upon performing in music education meant that, in addition to the development of skills, each pupil had the chance to 'be oneself in the here-and-now' (MTh2).

Notwithstanding this, the need for music teachers to work within a curriculum and therefore to implement a framework that should be progressive, successive and directional was clearly implied. In general, this was considered to be a positive challenge and represented the structures within society and the world at large:

> Music education has that directional aspect which, because of the structures we work in, also has certain staged development points along the way; assessment points, for example. (MEd6)

Concurrent with this was the view that for pupils who demonstrated a marked ability in music, the aim might be to encourage this potential towards the outcome of studying music at a higher level. For some, this may lead to considering music as a professional

career. The scope for differentiation within music education could facilitate the needs of pupils who were particularly able as well as those who presented difficulties with learning (MEd2).

For those speaking from a music therapy perspective, there was an underlying theme that aims in music education were largely pre-determined *as a result* of the curriculum. To an extent, therefore, aims would be linked to a generic framework rather than to individual needs and abilities. Likewise, there was emphasis upon the concept of a product. While there were opportunities for self-fulfilment, self-development and expression, these were achieved primarily through 'the product that is produced' (MTh5).

In summary, thirty-three different responses were presented; thirty-one different responses were made by music educators while six were given by music therapists. The prevailing view was that music education represented an opportunity to develop musical skills through purposeful musical activity. Underpinning this, however, was the importance of providing for pupils of all abilities a broad range of enjoyable musical activities and experiences. For some, this might represent initial steps towards higher levels of music making, possibly at a professional level. Yet for the majority of pupils, music education should be personally rather than professionally focussed and, at the very least, the subject *within* school should be a taster for musical opportunities *beyond* school.

(iii) *What are the areas of commonality between the two professions?*

RESPONSES FROM MUSIC EDUCATORS	%
Potential of music to reach out and reach within	33.3%
Development of communication skills	33.3%
Providing opportunities for emotional release	33.3%
The use of music as a tool to help pupils progress	16.6%
The actual influence of the music therapist or music teacher	16.6%
Potential of music to expand the mind	16.6%
Potential of music to provoke expression	16.6%
Working towards an end product	16.6%
The significance of listening to music	16.6%
The educational dimension of therapy	16.6%
The therapeutic dimension of education	16.6%
The subconscious therapeutic effects of music	16.6%
Creative involvement	16.6%
Means of providing colour in the lives of pupils	16.6%
The actual way in which a music teacher may use music when working with pupils who have special needs	16.6%

RESPONSES FROM MUSIC THERAPISTS	%
Creative involvement	40%
The experiential component	40%
The significance of listening to music	40%
The need to assess	20%
Paying attention to extra-musical factors	20%
The aesthetic response	20%
Potential of music to provoke expression	20%
Potential of music to encourage learning	20%
Potential of music to motivate	20%
Acquiring a sense of achievement	20%
The sense of anticipation within a structure	20%
The use of improvisation	20%
The scope within the Expressive Arts curriculum to consider therapeutic ways of using music	20%
The pupils themselves and how they can facilitate co-operation between music teachers and music therapists by means of complementing each other's working practices (e.g. the music therapist taking a 'difficult' child on a one-to-one basis in order to help the child participate more fully with others in a class environment)	20%

COMBINED RESPONSES FROM MUSIC EDUCATORS AND MUSIC THERAPISTS	%
Creative involvement	27.3%
The significance of listening to music	27.3%
Potential of music to reach out and reach within	18.2%
Potential of music to provoke expression	18.2%
Development of communication skills	18.2%
Providing opportunities for emotional release	18.2%
The experiential component	18.2%
The use of music as a tool to help pupils progress	9%
The actual influence of the music therapist or music teacher	9%
Potential of music to expand the mind	9%
Working towards an end product	9%
The educational dimension of therapy	9%
The therapeutic dimension of education	9%
The subconscious therapeutic effects of music	9%
Means of providing colour in the lives of pupils	9%
The actual way in which a music teacher may use music when working with pupils who have special needs	9%
The need to assess	9%
Paying attention to extra-musical factors	9%
The aesthetic response	9%
Potential of music to encourage learning	9%
Potential of music to motivate	9%
Acquiring a sense of achievement	9%
The sense of anticipation within a structure	9%
The use of improvisation	9%
The scope within the Expressive Arts curriculum to consider therapeutic ways of using music	9%
The pupils themselves and how they can facilitate co-operation between music teachers and music therapists by means of complementing each other's working practices (e.g. the music therapist taking a 'difficult' child on a one-to-one basis in order to help the child participate more fully with others in a class environment)	9%

Although this question prompted twenty-six different responses, only two of them were mentioned on more than two occasions. The use of creative involvement and the significance of listening to music were both alluded to three times. For those responses that were highlighted twice, the experiential aspect of music-making was either implicitly or explicitly cited as a common factor between the two fields. Music was considered to be an active process that required people to play and to sing, to compose and to improvise. Thus, both the pupil and the client were seen to be involved in listening to music which could then inform and influence the subsequent playing, singing, composing or improvising. This emphasis on the *doing* of music meant that opportunities were

available for the *development* of the individual. In particular, musical activity could facilitate aspects of expression in the therapy room as well as the classroom.

Linked to the above, was the potential of music itself to *reach out* to people and also to *reach within* people. The following two comments from music educators help to illustrate this particular purpose of music:

> [With music we are] trying to reach out to some pupils; to provoke reaction, expression and emotion, to develop communication skills. (MEd5)

> Music is something that helps to expand the mind; no matter how small those little brain cells are, music *reaches*. (MEd3)

Underpinning these areas of commonality was the notion that music, by its very nature, is therapeutic. And through the involvement of therapeutic activities and experiences lay the potential for educational development, for learning. This was manifest in the way that music could help people 'to progress, to develop and to go beyond the particular problem that they may have' (MEd6). As one music therapist pointed out, 'we're both using music to encourage learning, in whatever way we are wanting people to learn' (MTh3).

The view was expressed that the actual level of commonality depended upon the needs and abilities of the individual receiving either music education or music therapy. One music educator described how, when working with pupils whose needs were of a severe, profound or complex nature, there was a more obvious link between his form of interaction as a teacher and the way in which a therapist might work (MEd2).

Unlike the first two questions there was a closer numerical similarity between the responses from the two sets of participants: fifteen from the music educators and fourteen from the music therapists. Yet the responses revealed some interesting differences: the aesthetic dimension of music was mentioned only by a music therapist while the development of communication skills was cited by two music educators and no music therapists.

(iv) *What are the areas of difference between the two professions?*

RESPONSES FROM MUSIC EDUCATORS	%
Music teachers are required to work with larger numbers of pupils therefore the individual needs of pupils cannot be given the same priority as in music therapy	50%
Music therapists can take a more child-centred approach	33.3%
Music therapists work in more personal ways	33.3%
Differences in training	33.3%
Music therapists work at a deeper level	16.6%
Music therapists have more knowledge about individual needs	16.6%
Music therapists have to cope with more extreme forms of response	16.6%
Music therapists are more equipped to develop a single musical idea	16.6%
Music therapists have more specific aims	16.6%
Music therapists can be more spontaneous whereas music teachers have to adhere to a longer term plan	16.6%
Music therapy can facilitate freer expression	16.6%
Music therapy can focus more on developing imagination	16.6%
Music therapists follow a medical model whereas music teachers follow an educational model	16.6%
Music therapy is more affective	16.6%
Music teachers are more restricted by assessment requirements	16.6%
Music teachers have to adopt a rigid and tightly structured approach whereas music therapists can be more fluid and flexible	16.6%
Music teachers are more concerned with what pupils can take away from the lesson (i.e. what has been learnt)	16.6%
Music teachers have to prepare pupils for concerts	16.6%
Music teachers have to teach concepts	16.6%
Music teachers have to 'tick off' aims more	16.6%
Music teachers are informers, educators and disciplinarians all rolled into one	
Music teachers and music therapists are working towards the same things but at a different level	16.6%
Music teachers and music therapists deploy similar activities but are working towards different ends	16.6%
Music education is more competitive	16.6%
Music teachers and music therapists have different natures, music therapists have to be more patient	16.6%

RESPONSES FROM MUSIC THERAPISTS	%
Music therapists are not required to work within a curricular framework	60%
Music therapists accept and acknowledge non-musical behaviours	60%
In music therapy, assessment is a starting point whereas in music education it is an end point	60%
A music therapist has clinical autonomy	40%
Music teachers have to adopt a rigid and tightly structured approach whereas music therapists can be more fluid and flexible	40%
Music teachers are required to work with larger numbers of pupils therefore the individual needs of pupils cannot be given the same priority as in music therapy	40%
In music education the aims will be musical whereas in music therapy the music is used as a means to a non-musical end	20%
Music therapists can take a more child-centred approach	20%
Music therapists have to cope with more extreme forms of response	20%
Music education is analogous to food whereas music therapy is analogous to extra vitamins	20%
Music education is concerned with promoting development whereas music therapy is concerned with removing obstacles	20%
A music teacher thinks from 'top down' whereas a music therapist thinks from 'bottom up'	20%
A music teacher is essentially a performer whereas a music therapist is essentially a listener	20%
Music teachers work in a more behavioural way than music therapists	20%
Music teachers and music therapists have different codes of ethics	20%
Music therapists follow a medical model whereas music teachers follow an educational model	20%
Music therapists work at a deeper level	20%
Music teachers have to prepare pupils for concerts	20%
Music teachers have to 'tick off' aims more	20%
Emotional needs are more appropriately addressed by a music therapist	20%
Music teachers have more specific aims	20%
In music education there is more emphasis on deciding aims in advance of the lesson	20%
Music education is more product-based whereas music therapy is more process-based	20%
Children are encouraged to be more spontaneous in music therapy than they are in music education.	20%
Music therapy is helping to address the needs of lots of people who do not come under the education 'umbrella'	20%
Everyone should have access to music education but not everyone should have access to music therapy	20%

COMBINED RESPONSES FROM MUSIC EDUCATORS AND MUSIC THERAPISTS	%
Music teachers are required to work with larger numbers of pupils therefore the individual needs of pupils cannot be given the same priority as in music therapy	45.5%
Music therapists are not required to work within a curricular framework	27.3%
Music teachers have to adopt a rigid and tightly structured approach whereas music therapists can be more fluid and flexible	27.3%
Music therapists accept and acknowledge non-musical behaviours	27.3%
Music therapists can take a more child-centred approach	27.3%
In music therapy, assessment is a starting point whereas in music education it is an end point	27.3%
Differences in training	18.2%
A music therapist has clinical autonomy	18.2%
Music therapists work at a deeper level	18.2%
Music therapists follow a medical model whereas music teachers follow an educational model	18.2%
Music therapists have to cope with more extreme forms of response	18.2%
Music teachers have to prepare pupils for concerts	18.2%
Music teachers have to 'tick off' aims more	18.2%
Music therapists work in more personal ways	18.2%
In music education the aims will be musical whereas in music therapy the music is used as a means to a non-musical end	9%
Music therapists have more knowledge about individual needs	9%
Music therapists are more equipped to develop a single musical idea	9%
Music therapists have more specific aims	9%
Music teachers have more specific aims	9%
Music therapists can be more spontaneous whereas music teachers have to adhere to a longer term plan	9%
Music therapy can facilitate freer expression	9%
Music therapy can focus more on developing imagination	9%
Music therapy is more affective	9%
Music teachers are more restricted by assessment requirements	9%
Music teachers are more concerned with what pupils can take away from the lesson (i.e. what has been learnt)	9%
Music teachers have to teach concepts	9%
Music teachers are informers, educators and disciplinarians all rolled into one	9%
Music teachers and music therapists are working towards the same things but at a different level	9%
Music teachers and music therapists deploy similar activities but are working towards different ends	9%
Music education is more competitive	9%
Music teachers and music therapists have different natures, music therapists have to be more patient	9%
Music education is analogous to food whereas music therapy is analogous to extra vitamins	9%
Music education is concerned with promoting development whereas music therapy is concerned with removing obstacles	9%
A music teacher thinks from 'top down' whereas a music therapist thinks from 'bottom up'	9%
A music teacher is essentially a performer whereas a music therapist is essentially a listener	9%
Music teachers work in a more behavioural way than music therapists	9%
Music teachers and music therapists have different codes of ethics	9%
Emotional needs are more appropriately addressed by a music therapist	9%
In music education there is more emphasis on deciding aims in advance of the lesson	9%
Music education is more product-based whereas music therapy is more process-based	9%
Children are encouraged to be more spontaneous in music therapy than they are in music education.	9%
Music therapy is helping to address the needs of lots of people who do not come under the education 'umbrella'	9%
Everyone should have access to music education but not everyone should have access to music therapy	9%

Of the seven areas of questioning, this particular question prompted the highest number of different responses. While some of the differences were slight, the total number made was forty-three.

The respective significance attached to the individual pupil or client underpinned the key differences between the two fields. There were two main reasons for this: firstly, a difference in *context*(1) as the school-based nature of most teaching responsibilities meant that the teacher would likely be working with a class rather than an individual pupil (the response from five participants); and secondly, a difference in *content* as the teacher was contracted to teach according to a curricular framework whereas a therapist could focus entirely upon the needs of the individual client (the response from three participants). In turn, this allowed music therapists the opportunity to deploy a more flexible form of interaction. This applied to aspects of planning as well as to implementation. The following two comments from different educators help to exemplify this view:

> When children come to a therapist, the therapist has to work on his or her feet, see how the children respond and notice what their mood is that day. But as a class music teacher I've got to plan for the term and stick by that. (MEd4)

> The atmosphere is different. I have quite a rigid, tightly-structured approach in the classroom whereas music therapists work much more freely and open. In therapy you're more free to let the child direct. I'm the teacher, I direct my classroom, I organise. (MEd5)

One outcome of this issue represented a further difference between the two fields: namely, the area of assessment. While assessment was a requirement common to both music therapy and music education, the point was made by three participants that, within education, assessment was something that people worked *towards* and was determined in accordance with different curricular stages. In therapy, however, assessment was considered primarily as a diagnostic tool that could inform the therapist what to work

(1) With regard to this issue it is pertinent to note the example of a full-time music therapist (MTh3) who was normally working with 45 clients each week and a full-time visiting music specialist (MEd4) who was normally working with 900 pupils each week.

from and *with*. Furthermore, for those participants involved in the teaching of music, a degree of frustration was evident due to the emphasis that was being placed on assessment. As one educator commented, 'the examination tail that wags the dog' (MEd3). For her, this had the effect of limiting the *how* as well as the *what* of her teaching; the opportunity to be imaginative was constrained by the need to be instructive for purposes of assessment. Another participant claimed that assessment-led curricula would often lead to a competitive ethos permeating the classroom environment (MEd6).

The opportunity afforded to music therapists to accept and acknowledge non-musical behaviours was referred to on three occasions. In relation to this, one music therapist felt that music teachers could be more tolerant in their *perception* of musical responses. As an example, the therapist commented how (in her opinion) teachers might equate loud playing with being 'bad' or 'naughty'. By comparison, she felt it was important that 'people should be allowed to be loud' (MTh3). There appeared to be an implication in this view that while there may be differences regarding the individuals who *attend* either music therapy or music education, there might also be differences in relation to those who *administer* music therapy or music education. In certain ways, a therapist appeared to be more accepting of a wider range of musical responses. While two participants felt that these differences might be an outcome of the respective training experiences associated with both fields, one participant believed there to be a difference between the nature and personality of a music therapist compared with a music teacher, the therapist generally being more patient (MEd3).

Two participants expressed the view that music therapists are required to work with more extreme forms of response. Furthermore, while the therapist may be working in a musical form, the client might be responding in a manner that is not specifically musical. As one therapist commented:

> The child [in therapy] can be demonstrating rage, despair, awkwardness, passivity and the therapist is reflecting this back. (MTh6)

Aligned to this was the notion that the therapist worked at a deeper level than a teacher and from a viewpoint that was essentially psychodynamic. The observation was made that whereas a teacher would likely wait for a pupil to behave before the teaching could begin, the therapist would use music to meet the immediate behavioural responses of the pupil (MTh1). Thus, the therapist would begin rather than wait. This difference appeared to reflect the status of the music teacher in comparison to that of the music therapist. The latter (according to this same therapist) had a degree of clinical autonomy and medical responsibility that allowed him or her the 'freedom to work towards aims and outcomes that were not necessarily linked to an identified curricular framework'.

In summary, the number of different responses made to this question was similar between the two professional areas: twenty-five from the music educators and twenty-six from the music therapists. Differences were essentially contextual and these had an inevitable influence on the respective aims and outcomes that the therapist or teacher would work towards. While it was generally felt that music teachers and music therapists were both seeking to use music as a means of helping the individual child to progress, the particular ways in which music might be used - and how progress might be measured - would differ between the two forms of intervention.

(v) *How clearly can clinical needs be distinguished from special educational needs?*

RESPONSES FROM MUSIC EDUCATORS	%
Difficult to distinguish	50%
Unaware as to what the word 'clinical' meant	33.3%
Clinical needs are concerned with medical conditions	33.3%
Clinical needs are concerned with psychiatric disorders	16.6%
Differences in training lead to differences in thinking from either a clinical or an educational perspective	16.6%
The nature of the two professions leads to an expectation of differences between clinical needs and special educational needs	16.6%

RESPONSES FROM MUSIC THERAPISTS	%
Difficult to distinguish	60%
'Clinical' is not a helpful word	60%
I never use the word 'clinical'	40%
No difference between the two forms of need	20%
Unaware as to what the word 'clinical' meant	20%
'Clinical' refers to the model of referral-assessment-treatment-evaluation-discharge	20%
The term 'special educational need' provides a clearer picture as to the nature of the need	20%
The nature of the two professions leads to an expectation of differences between clinical needs and special educational needs	20%

COMBINED RESPONSES FROM MUSIC EDUCATORS AND MUSIC THERAPISTS	%
Difficult to distinguish	54.5%
Unaware as to what the word 'clinical' meant	27.3%
'Clinical' is not a helpful word	27.3%
I never use the word 'clinical'	18.2%
The nature of the two professions leads to an expectation of differences between clinical needs and special educational needs	18.2%
Clinical needs are concerned with medical conditions	18.2%
Clinical needs are concerned with psychiatric disorders	9%
Differences in training lead to differences in thinking from either a clinical or an educational perspective	9%
'Clinical' refers to the model of referral-assessment-treatment-evaluation-discharge	9%
The term 'special educational need' provides a clearer picture as to the nature of the need	9%

Of the eleven participants, six reported that it was difficult to distinguish between clinical needs and special educational needs. Three participants (one of whom was a music therapist) were not clear as to what the word 'clinical' meant. Furthermore, three participants (all of whom were music therapists) considered it to be an unhelpful word. In general, those from a music therapy background felt that it was a vague and socially

outmoded term. While people did not deny that the term was used, there was an element of suspicion as to why it was used. One therapist, for example, claimed that it was a piece of 'medical jargon' while admitting that it was 'global in the sense of it being used throughout human services' (MTh1). Indeed, this same person believed that music therapists might choose to deploy the word 'clinical' almost as a means of protecting the distinctiveness of their work.

Two music therapists, however, commented on how they would deliberately use the term 'clinically directed improvisation'. This seemed to give a specific focus and rationale for improvisation within music therapy. As one therapist claimed:

> Clinically directed improvisation is about putting the other person's needs before your own skill and enjoyment in improvising. It is about using music to take care of another person. (MTh5)

Two people reported that clinical needs applied to people who had a medical condition while one stated that it related to needs of a psychiatric nature. Similarly, those who were terminally ill were considered to have needs that would unlikely be met by a teacher; as one person commented, 'there's not much you can do educationally' (MEd5). Within an educational environment such as a school, there was an implicit sense that 'clinical' was synonymous with 'profound' or 'extreme' and that for pupils in this category, the intervention of a music therapist was more appropriate than that of a music teacher. One teacher sought to disassociate herself with meeting needs which were predominantly internal:

> If the need is inside the pupil (e.g. mental, psychological, psychiatric), that's when we get into difficulties. (MEd3)

The view was expressed that if there was a difference between clinical needs and special educational needs, this was due to differences in training between a music therapist and a music teacher and a subsequent difference in thinking. The particular forms of training, therefore, were felt to lead to an expectation of differences in needs; this suggested that the differences were not so much inherent within the pupil or client

but they were implicit within the professional attitude of the respective teacher or therapist. There was a clear notion from participants that a *need was a need* regardless of whether some might consider it to be clinical or special educational. Furthermore, those speaking from a music therapy perspective did not feel that special educational needs were the exclusive responsibility of teachers (educationalists). One therapist felt that this term helped to provide a clearer picture of what the need might be (MTh4). This seemed to relate closely to aspects of learning and to barriers that might be inhibiting the process of learning. Poor literacy, for example, represented a special educational need and an area that the teacher would be required to address. Linked to this, however, was the potential role of the therapist to work with difficulties that may be emanating from this need, such as difficulties with concentration. A music therapist, therefore, was perceived as someone who would 'support the educational needs of children' (MTh5). This same person suggested that therapists were 'addressing educational needs in the broadest sense; we're addressing emotional, psychological and developmental needs'.

In summary, there were ten different combined responses from music educators and music therapists to this question; eight different responses were from music educators and six from music therapists. There was an underlying sense that little was to be gained by seeking clarification between clinical needs and special educational needs. What seemed to matter most was the precise nature of the need, how this might be best met and who might be most suitably skilled to meet it. It was generally felt that when needs were health- rather than learning-related, the training, thinking and practical experience of a music therapist would be more appropriate than that of a music teacher. As one therapist explained, both healthcare and education have a philanthropic basis and are concerned ultimately with the most meaningful quality of life that each person may have (MTh1). Thus, the needs of the person, rather than the apparent need of either profession to promote and maintain a degree of exclusivity, were paramount.

(vi) *Due to an increasing emphasis on policies of inclusion, it would seem essential that both future and current teachers of music are given training as how best to work with pupils who have special educational needs. What form should this training take and who might provide it?*

RESPONSES FROM MUSIC EDUCATORS	%
Observation of a music therapist	66.6%
Students to work with the same children that they have observed the music therapist working with	33.3%
The music therapist to work in an advisory capacity with the music teacher	33.3%
The music therapist to work alongside the music teacher	16.6%
The music therapist to observe the work of the teacher or student	16.6%
Observation of an experienced SEN teacher	16.6%
Learning how to improvise in a 'following' rather than 'leading' role	16.6%
Tuition from music therapists at both pre-service and in-service levels	16.6%
A multi-disciplinary programme delivered by music teachers, music therapists and community musicians	16.6%
After-hours courses	16.6%
Provision of extra resources	16.6%
Information about disabilities	16.6%
Opportunities for all students to be more involved in activities which relate to the broad area of special needs	16.6%
Opportunities for training should define the areas of commonality but also emphasise that a boundary exists	16.6%
Music teachers to be allowed to engage more freely and musically with pupils who have special needs rather than focusing too much on curricular demands	16.6%

RESPONSES FROM MUSIC THERAPISTS	%
Developing awareness through practical/experiential activities	40%
Opportunities for training should define the areas of commonality but also emphasise that a boundary exists	40%
Learning how to improvise in a 'following' rather than 'leading' role	20%
Training needs to take place at pre-service level	20%
Provision of extra resources	20%
Information should be general rather than prescriptive	20%
Information on integration and inclusion	20%
A multi-disciplinary programme delivered by music teachers, music therapists and community musicians	20%
People should be informed as to where and how they can access information	20%
Music teachers to be allowed to engage more freely and musically with pupils who have special needs rather than focusing too much on curricular demands	20%

COMBINED RESPONSES FROM MUSIC EDUCATORS AND MUSIC THERAPISTS	%
Observation of a music therapist	36.4%
Developing awareness through practical/experiential activities	18.2%
Learning how to improvise in a 'following' rather than 'leading' role	18.2%
Provision of extra resources	18.2%
Students to work with the same children that they have observed the music therapist working with	18.2%
The music therapist to work in an advisory capacity with the music teacher	18.2%
A multi-disciplinary programme delivered by music teachers, music therapists and community musicians	18.2%
Opportunities for training should define the areas of commonality but also emphasise that a boundary exists	18.2%
Music teachers to be allowed to engage more freely and musically with pupils who have special needs rather than focusing too much on curricular demands	18.2%
The music therapist to work alongside the music teacher	9%
The music therapist to observe the work of the teacher or student	9%
Training needs to take place at pre-service level	9%
Tuition from music therapists at both pre-service and in-service levels	9%
Observation of an experienced SEN teacher	9%
After-hours courses	9%
Information about disabilities	9%
Information should be general rather than prescriptive	9%
Information on integration and inclusion	9%
Opportunities for all students to be more involved in activities which relate to the broad area of special needs	9%
People should be informed as to where and how they can access information	9%

Within the twenty different combined responses above, there is a clear sense that both current and future teachers of music should receive training with regard to this issue. Yet at the same time - from the perspectives of the music therapists interviewed - there was an element of uncertainty as to how this might happen and what the outcomes could be. This uncertainty was related to the possible blurring of boundaries between what music therapists and music teachers actually do. One therapist, for example, felt that if the distinctive value of music therapy was not emphasised, a teacher might 'feel' that he or she could potentially take over the responsibilities of a therapist (MTh4). This same person, however, believed that music therapists should be open about what they do and be able to pass on knowledge and expertise that would be helpful for the music teacher. This view was reinforced by another therapist who believed that through the process of being candid, music therapists could highlight what the specific differences between the two professions are (MTh5). Furthermore, in doing this - according to one music educator

- music teachers would then be better informed about what they could do, what they had in common with a music therapist and, most importantly, when it was necessary to request the specific services of a music therapist (MTh6).

Therefore, while the most prevalent view was that current and future music teachers should be afforded the opportunity to observe music therapists working with children with special needs, the four people who expressed this view were all music educators. Similarly, it was suggested by two music educators that student music teachers might experience a short placement with a music therapist. During this placement, they could observe the therapist working and then be provided with 'hands-on' opportunities themselves in which they would be observed by the therapist. As one educator said:

> . . . . like a 'crit' situation where the therapist can observe and then advise as necessary. (MEd2)

This was felt to be more beneficial than learning about theoretical perspectives of music therapy or watching video examples of a therapist. There was a need to be *in* the environment while working *with* the pupils.

It was pointed out by one music educator, who several years earlier had spent some time observing a music therapist, that there was more to be gained from this opportunity than the acquisition of skills, ideas and resources. For her, the experience had made her become more patient when working with pupils who had special needs; likewise, the ways in which she communicated as a teacher had been positively influenced by this period of observation (MEd1).

Notwithstanding the concern expressed above that a teacher, as a result of training, might perceive his or her role to be similar to that of a music therapist, two of the therapists reported that it may be helpful for a teacher to experience the role of a client. By providing a glimpse of the power of music therapy through experiential activities, teachers might acquire a wider view and the subsequent confidence to implement their own ideas in their own ways. Through activities such as turn-taking and improvising with

other people, there was the opportunity to *sense* the extra-musical dimension of shared musical interaction:

> Helping people to realise that the way you express yourself in music says something about your personality, your psychological state; this is very important. (MTh5)

One participant felt that due to the myriad curricular and assessment demands teachers had to cope with, a certain amount of musical sensitivity that might be expressed toward the needs of individual pupils had been 'knocked out' of them (MEd6). Thus, there was a need to get back to the roots of the musical experience and to re-capture the essence of making music with another person.

Two participants stated that teachers needed to become - or train to become - more spontaneous, more courageous and therefore more confident in the area of improvisation (MEd1 and MTh3). A notion of security within leadership was evident in the suggestion that the ability to *follow* the responses of another person was more challenging than the tendency to *lead* the responses of another person.

The issue of confidence, according to one therapist, might be addressed more meaningfully when music therapists intentionally held back the amount of information provided for music teachers. By deliberately not being prescriptive, therapists were encouraging teachers to take alternative and creative directions in the work that they undertook:

> Teachers need to have the confidence to try new things from the seeds of ideas that they have been given. That's how I would envisage training; offering some groundwork rather than prescriptions. (MTh3)

The point was made that music therapists were not the only people who might provide relevant training opportunities for teachers. Experienced teachers themselves who had worked extensively in the area of special education were considered particularly appropriate for passing on their expertise. Similarly, the contribution of community musicians was considered to be highly desirable towards the training of teachers.

In summary, the fifteen different responses from music educators compared to the ten different responses from music therapists highlighted a significant difference in priority. This was illustrated through the aspiration on the part of educators for observational, advisory and collaborative opportunities to be made available with music therapists. At no time in the interviews with music therapists were these aspects explicitly stated. For those therapists interviewed, the predominant view was that the experiential nature of improvisation and of creative musical interaction would help teachers acquire a client perspective. Furthermore, any training opportunities provided for music teachers should emphasise that while there may be some issues of commonality, an important and necessary boundary exists between the two professional areas.

(vii) *Would music therapists and music teachers benefit from working more closely together? In what ways might this happen? What views are held, for example, with regard to the music therapist acting in a consultative capacity with music teachers who are working with pupils who have special needs?*

RESPONSES FROM MUSIC EDUCATORS	%
Music therapists and music teachers would benefit from working more closely together	100%
The music therapist could work as a consultant to the music teacher	83.3%
The music teacher could assist the music therapist	33.3%
The music teacher could work as a consultant to the music therapist	16.6%
The music therapist and the music teacher could team-teach together	16.6%
The barrier between music education and music therapy should be broken down	16.6%

RESPONSES FROM MUSIC THERAPISTS	%
Music therapists and music teachers would benefit from working more closely together	100%
The music therapist could work as a consultant to the music teacher	60%
A formal interdisciplinary structure would need to be established if music therapists were to work in a consultative capacity	20%
The music teacher could assist the music therapist	20%
The music therapist could assist the music teacher	20%
Music therapy and music education training courses could have a stronger interplay	20%
A dual qualification in music therapy and music education could be offered	20%
More dialogue between music therapists and music teachers would ensure that each knew what the other was doing and that they would not feel mutually threatened	20%
The role of the music teacher would need to be revisited to ensure professional competence and practitioner responsibility were being upheld if teachers were to be working in more therapeutic ways	20%

COMBINED RESPONSES FROM MUSIC EDUCATORS AND MUSIC THERAPISTS	%
Music therapists and music teachers would benefit from working more closely together	100%
The music therapist could work as a consultant to the music teacher	72.3%
The music teacher could assist the music therapist	27.3%
The music teacher could work as a consultant to the music therapist	9%
The music therapist and the music teacher could team-teach together	9%
The music therapist could assist the music teacher	9%
The barrier between music education and music therapy should be broken down	9%
A formal interdisciplinary structure would need to be established if music therapists were to work in a consultative capacity	9%
A dual qualification in music therapy and music education could be offered	9%
More dialogue between music therapists and music teachers would ensure that each knew what the other was doing and that they would not feel mutually threatened	9%
The role of the music teacher would need to be revisited to ensure professional competence and practitioner responsibility were being upheld if teachers were to be working in more therapeutic ways	9%

All eleven participants agreed that music therapists and music teachers would benefit from working more closely together. More specifically, eight participants believed that the music therapist could work as a consultant to the music teacher; of these eight, three were music therapists. In this way, the therapist could advise music teachers on the work that they were doing as part of his or her peripatetic responsibilities and return to visit the teacher at regular intervals. This would help to alleviate the shortage of music therapists in comparison to the number of pupils who would benefit from this form of interaction. It would also help to enhance the knowledge and awareness of teachers working in this specialist area. Thus, there was scope for complementing each other's work which would be of subsequent benefit for the pupil. The following example from a music educator illustrates how a teacher might learn from the way in which a therapist deployed rhythmic improvisation:

> [We could discuss how this activity might] lead into a musical understanding which I as the teacher can link to a piece of music by another composer. I can also link it to their own musical expression and encourage the pupils to invent their own pieces of music and so on. For the child, however, who has severe learning difficulties, that will probably not be the end of what they are doing; they won't be understanding, or at least it's hard to measure whether they understand the piece of music, or that they can engage [consciously] in the creation of a composition. So it operates in a different way for them but, nevertheless, there is this area of commonality. (MEd6)

It was suggested that a model for this level of collaboration could be witnessed in the relationship between teachers and speech and language therapists. This also represented an area of disagreement as the following two contradictory statements indicate:

> It's interesting that for many years there has not been either the polarisation or the suspicion between speech and language therapists and educators. There's an acknowledged area of exchange where those two come together. It's unfortunate that this has not been the situation in the area of music therapy. We need to break down the barrier that appears to exist between music education and music therapy. (MEd6)

> Music therapy is a specialism. Teachers are all working with language yet they don't claim to be speech and language therapists. They bring in the expensive speech and language therapist when they need to do that specialist work. It's important that we [music therapists] have some pride in what we have to offer. (MTh5)

One music therapist felt that the changes in relationship observed in recent years between doctors and nurses, and also between psychologists and teachers, were testament to the positive outcomes of different professionals working more closely together (MTh1). This same person also suggested that a dual qualification in music therapy and music education could be offered.

The point was made that if a music therapist were to adopt a consultative or advisory role, then he or she would need to be properly trained to do so (MTh4). This should be the choice of the individual therapist rather than a professional requirement. Furthermore, among the participants, the *task* of consulting was not considered to be a reciprocal process as only one person proffered the view that a music teacher might work as a consultant to a music therapist (MEd6).

In summary, six different responses were made by music educators and nine from music therapists. It is interesting to note that out of the eleven different combined responses only three were made on more than one occasion. While there was unanimity in the view that benefits would accrue from working more closely together, there was concern that this should be formalised within a proper interdisciplinary structure in order to ensure that ethical responsibilities were not compromised. Therefore, while the perceived closeness of collaboration between other professions had created a momentum that would be difficult to resist in both professional areas, music therapists were clinically accountable in a way that music teachers were not.

CHAPTER 5 ANALYSIS OF FINDINGS

The purpose of this chapter is to analyse the findings presented in chapter 4 and discuss these within the context of the earlier review of literature. This will involve a synthesis of the participants' concerns and aspirations with current theoretical perspectives on music therapy and music education. In so doing, it will be important to note the particular ways in which the findings are illustrative - or not - of the literature chosen to be reviewed. This will subsequently inform the response to the primary research question and help to indicate the extent to which motivation exists for theoretical interdependence between the two fields. The implications of this will form the main part of chapter 6.

For ease of reference, the structure adopted in chapter 4 will be repeated here; each of the seven questions will therefore be presented in turn and considered in light of the literature review. This will include reference to the general fields of education and therapy as well as to the respective musical domains.

(i) *What are the kinds of aims that a music therapist would most frequently work towards?*

The emphasis placed by the participants on the development of communication skills and the facilitation of self-expression through music could also be observed in the literature. With regard to this thesis, it seems reasonable to infer from certain authors that these particular aims might be encouraged through opportunities for musical performance. As suggested by Aigen (2004), Maratos (2004), Powell (2004) and Turry (2001), the channeling of communication and self-expression through performance activities can, for some clients, have clear therapeutic benefit. While it may be argued that the respective participants were not specifically aligning communication and self-expression to contexts of public performance, there is a notion that the authors mentioned above recognise the therapeutic value of this form of activity and that music therapists might choose to consider this as a potential objective.

The importance attached to the enhancement of emotional experience as a therapeutic aim (Aigen, 1996) was referred to in the interview responses when discussing the resolution of emotional issues. Indeed, the actual enjoyment of participating in musical activities was considered an outcome of this form of interaction and was manifest in the way in which opportunities for play and spontaneity featured prominently. The comment made by an educator, however, that an aim in music therapy might be to provide 'a form of relief or escapism' (MEd5) did not appear to be supported by the literature. Thus, while it was considered important that therapy should facilitate opportunities for self-expression (Laing, 1996), this was not the same as *self-escapism.*

The significance that participants attributed to the needs of the individual may be seen to relate closely to the literature. The rationale for therapy presented by Combs (1989) as 'the universal need of the organism for maintenance and enhancement of self' (p. 94) was evident within the views of three participants. Thus, it is when the individual is somehow restricted in this process of self-maintenance and/or self-enhancement that the need for therapy becomes apparent. Likewise, parallels may be drawn with Rogers' client-centred philosophy (1998) and Maslow's theory of need gratification and the continuous process towards self-actualisation (1968). The comments made by participants did not suggest there might be *too* much emphasis placed on the needs of the individual and that as a result this could lead to a potentially unhealthy degree of self-centredness. The concerns expressed by Furedi (2004), and Lasch (1991) were not echoed by the participants.

The way in which music therapy might facilitate meeting the needs of a group did not seem to feature explicitly as an aim considered by the participants. Thus, the views of Lee (2003), and Davies and Richards (2002) were not expressed in the interviews. Instead, while there was scope for a music therapist to work in a class setting, the therapist's aims would essentially be concerned with the needs of particular individuals within the class, rather than the class as a whole. Yet it is highly likely that a significant outcome of this would be a more integrated class and, in this sense, the need for music

therapists to be sensitive to matters of context - as highlighted by Pavlicevic and Ansdell (2004) and Stige (2002) - is implied.

The development of life skills that was felt to feature in music therapy by the participants had interconnecting threads with the literature. This was expressed, for example, by Krout (1986) and Codding (1982) when discussing forms of learning in music therapy. The view of Gaston (1968) that the chief concern of the music therapist was to '[elicit] changes in behaviour' (p. 292) resonated with participants' statements pertaining to self-awareness and self-discipline. The aim of developing musical skills through participation (as suggested by MTh5) could be observed in the work of Wood, Verney and Atkinson (2004).

In conclusion, there appeared to be a close sharing of views between those expressed in the literature and those voiced by participants. The comment made by a therapist who considered an aim of therapy to be the removing of obstacles (MTh2) was an implicit theme in the literature. In particular, this comment may be seen to have foundation in one of the three perceptions of therapy as suggested by Combs (1989); namely, that of *sickness-remover*. Thus, there appeared to be a general consensus that the aims held by a music therapist would have a specific *person-focus* and that music was being used for this essential humanistic purpose rather than the acquisition of musical skills *per se*.

(ii) *What are the kinds of aims that a music teacher would most frequently work towards?*

As was noted in chapter 4, the responses to this question indicated a degree of openness as to what the aims of a music teacher might be. Indeed, this was the clear impression from those participants whose profession was located within music education. For those commenting from a music therapy perspective, it was unanimously felt that the central concern of a teacher was the development of musical skills. The potential for music education to go beyond this skill-based remit (according to therapists) did not feature so prominently. It is possible that this contrast of opinion is a consequence of the different populations with whom the two professions are involved; that is, while music therapists in

schools will work almost exclusively with pupils who have special needs, music teachers will work with those pupils *in addition* to those from the whole spectrum of needs and abilities. Thus, while music education is for all, music therapy is for some and those who work with *only* some might have a restricted view of the different ways in which music may be used for the benefit of all.

This point may be taken further in the sense that music educators who were interviewed wished to place more emphasis on the development of non-musical areas but were frustrated in their attempts to do so largely as a result of assessment structures. There was a clear feeling of being *held back.* In addition, music educators believed that the opportunities for *learning through* the subject of music as promoted, for example, in the *National Guidelines: Expressive Arts 5-14* (1992) were no less important than the development of musical skills and knowledge. Such views resonate closely with the concern for the *whole* child in music education as expressed by Regelski (1981) and Paynter and Aston (1970). This could be observed not only in relation to how music education was seen to address many areas of development - such as social interaction and teamwork - but also in the way that the whole child represented the starting point from which aims exclusive to music would subsequently (rather than initially) be considered.

A central aim of music education, therefore, was the development of personal attributes through the participation and experience of musical activities. The comment from one participant that music education was 'personal developmental' (MEd6) would seem concurrent with Elliott's concern that it should facilitate the development of self-growth and self-knowledge (1995). The view expressed by Elliott that such development was a consequence of 'the *pursuit* of musical competency and excellence' (p. 181) was prevalent in the participants' desire for a stronger balance between musical and personal development. Likewise, a parallel may be drawn with Swanwick's belief in the capacity for music education to promote the 'feelingful *and* meaningful' aspects of music itself. (1996, p. 61).

The enhancement of the *self* as a result of music education was considered possible through creative and expressive activities. There appeared to be an underlying notion that the process of expressing was not only desirable but also growth-related. Yet there did not seem to be a distinction made between the *act* of expressing and the *art* of expressing. This was discussed by Graham (1998) in his wish to distinguish between expression (as an act) and expressiveness (as an art). While the former was primarily concerned with the releasing of emotions, the latter was a vehicle for artistic imagination; to an extent, the refining of emotions. The concern held by Hirst and Peters that self-expression should not be 'mere self-expression' but be creatively informed (1980, p. 32), and Elliott's inclination to distinguish between creativity and 'spontaneous originality' (1995, p. 221) were not raised by the participants. This difference in intent did not appear to translate as differences of aim in music education according to the participants.

Likewise, the strong difference of opinion expressed by Reimer (1989) and Elliott (1995) concerning the value of music education as aesthetic education was not highlighted as an issue by the participants. The point made by Schalkwijk (1994), however, in relation to the emphasis given to product over process for a music teacher (at least in special education) was alluded to by three of the participants.

A common thread between the literature and the responses from participants was the value attached to the quality of the learning environment. The view held by Maslow that an environment affected by anxiety 'kills curiosity and exploration' (1968, p. 67) would seem to be endorsed by the participant who claimed that her music department represented 'the *feelgood* department' (MEd1). To an extent, therefore, a music department within a school had a particular advantage in the way that it might foster curiosity and exploration. In so doing, an aim of a music teacher would be to ensure that his or her department was essentially a safe place within which one might express, create, learn and grow.

In conclusion, the assertion made by Bruscia (1998) that within music education the learning of music was the ultimate goal reflected the view of those participants from a

music therapy background. Similarly, the emphasis placed on skill development as a rationale for the curriculum, as suggested by music therapists, would likely have been welcomed as sound reasoning for education in general by Hirsch Jr. (1999). Music educators, however, while not negating the development of skills were keen to embrace the potential for aims in music education to go beyond this and into areas of personal development. For music teachers, the apparent restrictions of the curriculum had almost heightened their desire to deploy the *means* of music towards ends that were not *only* musical. And central to this was the provision of enjoyable musical experiences.

(iii) *What are the areas of commonality between the two professions?*

In chapter 2.4.1 the point was made that the two main commonalities between music education and music therapy were music and people. Thus, it is the *doing* of music *by* people that is embedded in both professional areas. In addition, music has an effect *on* people in education as well as in therapy. These components were evident in the four most frequently mentioned responses to this question: creative involvement, the significance of listening to music, the potential of music to reach out and reach within, and how music can be used to provoke expression. One might infer from these points that music has an inevitable therapeutic dimension. This would seem to be the view of Odam (1995) when he writes that '[music] therapy is not merely medicinally helpful to those in distress or special need, but is fundamental to all of us' (p. 14). Therefore, music therapy *itself* might be deployed as a common form of interaction amongst disparate populations.

The active, creative involvement that comprises both fields is widely articulated by several writers. In music education, for example, Elliott (1995) speaks of the importance of *musicing* - as mentioned earlier, a concept largely attributed to Small (1987). With regard to the benefits that may be acquired through listening to music, these have been articulated by (among others) North, Hargreaves and O'Neill (2000) and Boyce-Tillman (2000). Within the music therapy literature, examples of the creative use of music include Ansdell (2000), Aigen (1995a), and Nordoff and Robbins (1977). Similarly, Pavlicevic (2003) and Achenbach (2002) - in their respective books entitled *Groups in*

Music - Strategies from Music Therapy and *Creative Music in Groupwork* write from their perspectives as music therapists but with the intention that their suggestions may be adopted by a diverse range of people who use music with groups.

A parallel may be drawn between the views of two participants who considered the experiential component to be a commonality and the opinion of Leite (2002) that the opportunity for educators to experience creative activities was the most appropriate means of informing them about music therapy.

As was noted in the participants' responses, an educational dimension to therapy and a therapeutic dimension to education suggest an interrelation between learning and therapy. Within the literature pertaining to education and therapy in general, Sotto, for example, claims that while a client may be learning as a result of therapy, it is essentially 'tacit' and 'non-verbal' (1995, p. 104). Similarly, Combs (1989) emphasises that in therapy a client is learning mainly through the exploration of 'personal meanings' (p. 85); not least because (s)he is learning from the therapist as a person rather than as a provider of external knowledge and skills. The work of Rogers (1998) with regard to 'Student-Centered Teaching' (pp. 384-428) and Caspari (Forum for the Advancement of Educational Therapy and Therapeutic Teaching, 1997) concerning educational therapy are also relevant here. Therefore, while there would appear to be a degree of commonality between the concepts of learning, skill-development and progression, the context within which they are situated determines the precise nature of these concepts. This would appear to translate to the musical domains of therapy and education and is prevalent within the respective views of Pavlicevic and Ansdell (2004) and Paynter (1992).

(iv) *What are the areas of difference between the two professions?*

Within the literature selected for review, the point was made that while the subject of music education was linked to a curricular framework, the teacher should ensure that it is based on personal and affective qualities and thus avoid being over-prescriptive with a strong cognitive emphasis (Finney 1999 and Regelski 1981). This would seem to contradict the view of Hirsch Jr. (1999) who felt that the transmission of factual

information and acquisition of skills should feature more than is currently the case. However, while the requirement of the curriculum was voiced as one of the main differences between music education and music therapy by those interviewed, it did appear that participants from a music education background wished to embrace the sentiments of Finney and Regelski yet felt enforced to implement the curriculum according to the perspective of Hirsch Jr. In particular, the area of assessment (which was noted as a further difference between the two professions) seemed to be more constraining in practice than it did within the views of authors. The educator who voiced concern of the 'examination tail [wagging] the dog' (MEd3), would likely trade this emphasis for Swanwick's view that qualitative musical experiences should be the foundation of subsequent musical learning (1999). Indeed, it was the need to quantify that which is essentially qualitative that music educators found to be restricting, with some yearning for the apparent degree of spontaneity and flexibility afforded to music therapists. Likewise, as Darrow (1996) claimed, while the use of continuous assessment procedures will be utilised by music therapists, the assigning of grades to measure musical progress would almost certainly not feature.

The different forms of behaviour and response of those who attend music therapy (or at least who *should* attend) was prevalent in the views of participants as well as of authors. The comment made by Nordoff that 'Some children can take a little teaching, some can't. It depends on the child.' (Aigen, 1996, p. 21) was echoed by the music therapist who claimed that music therapy should be available only to those pupils 'who can't make use of what's on offer in music education' (MTh5). To an extent, this would seem to contradict the desire of Regelski (1981) that music education should be concerned with the 'process of individuation' (p. 62) and the opinion of the music educator that music had the potential for differentiation and should be used to 'reach out' to pupils (MEd5).

With regard to those who administer either therapy or education, the responses from participants in both fields alluded to the *personal* dimension of the individual - and the need of the *person* to work at a deeper level - as being more significant in music therapy

compared to music education. This suggests that an inner strength is a necessary pre-requisite for a music therapist. The quality of empathy needed by a therapist in his or her work is well-documented by Rogers (1998) and Maslow (1968). Similarly, Bunt and Hoskyns (2002) discuss the significance of the 'therapeutic attitude' and 'therapeutic presence' within the context of music therapy (p. 37). Thus, while there is a sense that a music therapist may *appear* to be especially patient and gentle (MEd3), such manifestations of *containing* would seem to be a particular strength and the hallmark of an effective practitioner. Indeed, Reiff (1987) believes that the strength required of a therapist to remain unshockable comes not from 'binding sentiment but critical detachment' (p. 69).

The requirement of music teachers to prepare pupils for concerts and the observation that music education is essentially product-based while music therapy is more process-oriented was not a unanimous view in the literature. While Bruscia (1998) and Schalkwijk (1994) would likely endorse this as a difference between the two fields, O'Callaghan, (2005), Powell, (2004) and Turry (2001) maintain that these particular aspects can also feature in the work of music therapy.

In conclusion, it was noted in chapter 2.5.4 that, according to Bruscia (1998), music learning is the ultimate goal in music education whereas it as used as a means to end in music therapy. This particular view of music education was not shared by authors such as Finney (1999) and Elliott (1995) who were keen to promote a stronger humanistic emphasis to this subject area. Neither was it prominent in the statements made by participants as only one person articulated this as a difference (MTh4). Therefore, what was considered to be a central assertion made by Bruscia regarding the differences between the two fields would appear to find little support in either the literature or the responses from those interviewed.

(v) *How clearly can clinical needs be distinguished from special educational needs?*

This question is largely concerned with terminology and the possible influence that terminology can have on subsequent forms of intervention. And it is here that disparities

become evident. While it is the case that the term 'special educational needs' is accepted and used widely within personal and professional vocabularies, the same cannot be said for 'clinical needs'. On reflection, the writer feels that this is the underlying reason why those interviewed from a music therapy background were not comfortable with this term. Three out of the five interviewed did not find it helpful and two stated that it was a word they chose not to use. This would seem to resonate with the views of Goll (1994) and his preference for the term 'Special Educational Music Therapy'. Indeed, Goll is anxious that terminology which appears to set apart the individual from society should be discouraged.

An examination of the data, however, reveals that it is the term 'clinical needs' rather than 'clinical' that is problematic. The claim made by two therapists that their work was based on the use of 'clinically directed improvisation' concurs with the definition of 'clinical' (pertaining to music therapy) as presented by Wigram, Pedersen and Bonde (2002). Yet within this same definition, the authors state that 'clinical' can often 'refer to an approach where one is scientifically detached and strictly objective' (p. 316). Arguably, it is this perception of clinical work that is not being welcomed by music therapists. Furthermore, the concerns of Lee (2003) and Ansdell (2000) that music therapy should embrace the aesthetic dimension of music itself would seem incongruent with the notion of scientific detachment. It may also be argued that the description made by one music therapist that clinically directed improvisation was concerned with 'using music to take care of another person' (MTh5) does not sit easily with being 'strictly objective'. The humanity of the music therapist and the relationship between the therapist and client will, to an extent, be subjective and emotionally charged while contained within a professional (clinical) context. This compares closely with the definition of clinical improvisation presented by Wigram (2004):

> The use of musical improvisation in an environment of trust and support established to meet the needs of clients. (p. 37)

Throughout the literature pertaining to music therapy, there are references to clinical strategies and interventions that a therapist may choose to deploy (Aigen, 1996), the use of clinical forms of assessment (Wigram, Pedersen and Bonde, 2002) and the importance

of clinical settings in which music therapy might take place (APMT, 2002a). There does not, however, appear to be literature referring explicitly to clinical needs. The notion of *clinical*, therefore, appears to relate to the attitude and expectations of the therapist rather than something that is *within* the client. The view expressed a music educator (MEd6) that such attitudes and expectations will largely be an outcome of the training course followed can also be observed in the literature. Bunt and Hoskyns (2002), for example, claim that the profession of music therapy needs to consider:

> . . . . the development of advanced clinical trainings to bring us more in line with directions in Europe, other clinical professions and to safeguard the future of our state registration through our continued professional development; (p. 317)

In terms of the most meaningful form of intervention, it was suggested by two participants that a point came when the severity of need of the individual child required to be addressed by a music therapist rather than a music teacher. There was an implicit sense of a spectrum of needs rather than two categories in which one was marked 'clinical' and the other 'special educational'. When the needs were considered to be 'profound', 'extreme' or 'psychiatric', for example, then it was felt that the skills and experience of a music therapist would be most suited (MEd2 and MEd3). A parallel may be drawn here with the literature when it was noted that in the areas of physical, emotional and mental health, a point was also reached when the emphasis needed to be on treating rather than teaching, and when the form of intervention moved from educational to medical (Wilson, 1969). In particular, the triadic definition of therapy by Combs (1989) could be differentiated to align the roles of health-promoter and sickness-preventer to the teacher, with the therapist being responsible for the role of sickness-remover.

A further comparison with the literature may be observed in the response of one music therapist who claimed that special educational needs were not the exclusive responsibility of teachers; indeed, this person felt that 'special educational needs' provided a clearer understanding of the nature of the particular need and how this might then be addressed (MTh4). This would appear to represent an example of how music therapists have

'strayed from promoting "well-being" into what might reasonably be termed areas of education' (Welch, Ockleford and Zimmermann (2001, p. 12).

Arguably, the widening of the conceptualisation of special educational needs has led to an assumption that this concept has become all-embracing. The increase in the labelling of children with a particular form of disability or disadvantage has, according to Furedi (2004), resulted in a greater number of children who are considered *in* need. Just as it seems difficult to neatly arrange needs into the two categories relating to this question, so too does it appear inappropriate to highlight the sense of *deficit* that the term 'clinical' might imply and, likewise, 'special educational' may not do justice to the medical foundations of certain needs.

In conclusion, the responses of six participants (54.5%), combined with the literature reviewed, indicate that clinical needs cannot be clearly distinguished from special educational needs. Yet while this particular terminology might be insufficient, participants generally agreed that the needs of individuals would at times require a therapeutic rather than an educational intervention. In this sense, it would appear that there is a clear correlation with the four levels of practice as suggested by Bruscia (1998). Thus, while the profession of music education may contribute to the auxiliary and augmentative levels, this would not be satisfactory at the intensive level and, in particular, at the primary level. In light of the *lack* of music therapists, the *prevalence* of music teachers, and the *increasing* number of pupils being identified with special needs, a central issue would appear to be how the distribution of skills of different professionals are fairly and appropriately aligned to the diverse needs of pupils.

(vi) *Due to an increasing emphasis on policies of inclusion, it would seem essential that both future and current teachers of music are given training as how best to work with pupils who have special educational needs. What form should this training take and who might provide it?*

While the emphasis in the previous questions has largely been concerned with the special needs of pupils and the nature of the two professions in relation to these needs, this question explores the needs of teachers in light of their responsibilities in this area. As an increasing number of music teachers are required to work with pupils who have special needs, the issue of appropriate training becomes more pressing. The responses given by music educators to this question suggest a gap exists between what music teachers feel *able to do* and what they feel they *need to be able to do.* While this was also acknowledged by music therapists interviewed, a degree of uncertainty on their part was evident regarding the quantity and quality of training that might be provided for music teachers working in this sector.

By comparing the responses of participants – particularly educators – with the literature reviewed, there does seem to be a mismatch between what music teachers would like to receive and what they are able to receive. To an extent, this is an outcome of the required level of confidentiality that permeates the various health professions. Thus, while music educators expressed a strong desire to observe *at first hand* the work of a music therapist, the Code of Professional Ethics and Conduct to which music therapists must adhere (APMT, 2003) appears to dissuade this arrangement. Indeed, even for the presentation of video and audio material, music therapists must:

> [Secure] written consent for all video/audio recording of clinical material from client and/or parent/guardian prior to recording the sessions, in accordance with the APMT [Association of Professional Music Therapists] illustrative records guidelines. (p. C.7)

For, as Wengrower (2001) points out, the importance of privacy between therapist and pupil(s) is a hallmark of the therapeutic relationship that requires to be maintained and respected. Furthermore, the suggestion that student teachers of music might have a placement opportunity with a therapist – which would involve, firstly, observation *of*, followed by hands-on experiences *with* pupils who have special needs – is also in breach of the APMT Code of Professional Ethics and Conduct:

> [Music therapists] should refrain from delegating duties to unregistered persons, except in the case of Music Therapy students in training, in which case the therapist for that delegation must assume full responsibility. (p. C.8)

The fact, however, that music therapists are often asked to 'contribute a basic introduction to music therapy on teacher-training courses' (Bunt, 1994, p. 170) raises the question as to what, precisely, they should contribute. Assuming the necessary consent has been granted, there may be opportunities for video/audio analysis of case study material. This would allow students to see and hear what music therapists actually do and represent the process of *informing* as suggested by Leite in her article, *Music Therapy for Educators: Are we informing or training?* (2002). For Leite, however, the opportunities for teachers and student teachers to take part in experiential activities, symbolised the most valuable form of learning while providing a heightened sense of client perspective. A parallel may be drawn here with the responses from two music therapists (MTh2 and MTh5); indeed, this was one of the two most frequently mentioned responses from this professional group.

Yet the responses of music educators indicated a desire to receive more than a basic introduction to music therapy. A period of twelve years has elapsed since Bunt's statement and, throughout this time, the implementation of continuing professional development has required teacher educators to provide suitable courses and modules that can meet the needs of teachers across the curriculum. In terms of policy requirements, this may be observed in *A Manual of Good Practice in Special Educational Needs* (SOEID 1999). With regard to the present writer, this is an area in which he has been regularly involved. As part of this, he has deliberately sought to move from *informing* to include aspects of *training.* Central to this, has been the teaching of improvisation that would allow music teachers to engage with a greater degree of personal-communicativeness, thus enriching their work with pupils who have special needs. And for those pupils, learning may be one outcome of a therapeutically-informed yet educationally-led experience. Furthermore, this might enhance the confidence and ability of music teachers in the delivery of inventing activities that form a key part of the music curriculum. As the writer suggests:

> Is it not in the moment of improvisation (spontaneous, meaningful and shared musical interaction) that the therapist meets the client and that the process towards wholeness can begin and culminate? This, I believe, represents a flaw in the music education system: that the reluctance to teach Inventing has led to a diminished musical experience for the pupils - and therefore a diminished *life* experience. Here then is one reason why a closer collaboration between music therapy and music education might be desirable. The power of improvisation - and the acquisition of the ability to improvise in more clinically directed ways - needs to be unleashed in the mainstream classroom. (Robertson, 2000, p. 44)

Thus, the writer is proposing that the rationale for improvising promoted by music therapists when working with pupils with special needs, might also be deployed by music teachers when working with pupils who may or *who may not* have special needs. While Hargreaves (1996) suggests that improvisation within music education is most appropriately situated in 'jazz, pop and many non-Western forms of music' (p. 59), Sloboda and Davidson (1996) claim that an improvisatory approach would allow pupils a greater degree of fun and flexibility when learning music within the predominantly classical tradition. They write:

> We suspect that those individuals for whom music is "all work and no play" will never achieve the highest levels of expressive performance. The achievement of the right balance of freedom and discipline is perhaps the single most challenging task for parents, teachers and young musicians. (p. 187)

With regard to this issue, it is pertinent to note that training need not be *provided* by another person. Even if a music therapist refused to assist music teachers in the development of clinical improvisation techniques, teachers would still be able to study books which do precisely that; the most recent being *Improvisation - Methods and Techniques for Music Therapy Clinicians, Educators and Students* by Wigram (2004). Knowledge, therefore, cannot be withheld.

In addition to the informing and/or training that might be deliberately applied by a music therapist when working with teachers, the impact of the therapist *as a person* can have significant value for the professional development of the teacher. This was voiced by one music educator who, as a piece of formal and approved research, was fortunate enough to observe a therapist over a period of time (MEd1). This would appear to echo the suggestion by Hirst and Peters (1980) that a teacher should 'allow glimpses of himself as a human being to slip out and be receptive to this dimension of his pupils' (p.

100). And the opinion expressed by one music therapist that 'teachers need to have the confidence to try new things from the seeds of ideas that they have been given' (MTh3) is a similar example of how a degree of subtlety on the part of the therapist can have greater impact on the subsequent work of the teacher than an approach more akin to spoon-feeding.

In conclusion, the claim by Welch, Ockleford and Zimmermann (2001), that there is a lack of professional development courses in music education for teachers working with pupils with special needs, is reflected in the desire expressed by music educators interviewed to acquire such training. Yet issues pertaining to client confidentiality and ethical procedures make it unlikely that teachers will have the opportunity to observe the work of a music therapist. Therapists, therefore, need to think creatively about how they might assist teachers in this process while maintaining the necessary professional and clinical boundaries. To an extent, each therapist will decide whether to adopt an approach that is essentially information-based, experientially-informed or person-influenced. As has been noted, however, the potential for a communicative form of improvisation, similar in foundation to that used by a music therapist, would likely be welcomed by teachers for their work in the mainstream as well as the special needs environment.

(vii) *Would music therapists and music teachers benefit from working more closely together? In what ways might this happen? What views are held, for example, with regard to the music therapist acting in a consultative capacity with music teachers who are working with pupils who have special needs?*

In considering how the responses to this question can be practically implemented, it is necessary to provide a sense of context to clarify the directions which may be taken. For it is at this point that the pragmatic outcomes of potential theoretical frameworks become the focal point. And it is at this point, too, that the interrelationships between content, consumers and providers may reveal new forms.

If this notion of *newness* is to take root, then it is likely to be accompanied by varying degrees of excitement and apprehension. When discussing the perception of the arts

therapies within educational settings, Leite (2002) describes this as a 'shock of cultures' (p. 12). Yet this collaboration of cultures would appear to represent the rationale for New Community Schools in Scotland (Bloomer, 2003) and inter-professional ways of working (Milburn and Wallace, 2003). To extend Leite's choice of phrase, the combination of different cultures will likely become less shocking if they are required to operate in the same setting and with the same people.

Similarly, *The Education of Pupils with Language and Communication Disorders* (HMI, 1996) and *A Manual of Good Practice in Special Educational Needs* (SOEID, 1999) demonstrate the view at Scottish Executive level that collaborative ways of working are moving from a recommendation to a requirement. The claim made by the music therapist that when a pupil has language difficulties, schools will 'bring in the expensive speech and language therapist' (MTh5) would appear to fall short of the rationale for the HMI (1996) document. As noted by Forbes (2001), this report seeks to pay more than lip service to mutual trust and respect between teachers and speech and language therapists, and that it is specifically requesting collaboration at the levels of training, planning and implementation.

It is reasonable to suggest, therefore, that collaborative forms of working alongside teachers will not be restricted to the profession of speech and language therapy. Within the area of group work, for example, it is the norm rather than the exception that a music therapist will conduct a session in the presence of another person, such as a teacher. Indeed, this arrangement was welcomed by one music therapist in preference to *talking* about music therapy when he said:

> So, when teachers ask me "it would be really nice to pick up some ways of working from what you do", I'm left rather exasperated because I don't know what to say. Unless they come in with me; if somebody comes in with me and works as an assistant that's fine, and probably they'll learn something. But they'll probably learn from the *being in there*, not from what I say. (MTh2)

There would seem to be potential, therefore, to meaningfully utilise the presence of an additional person for professional purposes.

As was noted in the previous chapter, all of the participants believed that music therapists and music teachers would benefit from working more closely together. By comparing the range of their suggestions with the literature, there appear to be four ways in which collaboration between music therapists and music teachers might take place. The opinion expressed by the music therapist above represents the arrangement of *observing a music therapist.* Secondly, the recommendation of Strange (1987) that within a school environment music therapists should facilitate 'a trusting and open relationship with one's colleagues' (p. 31) would concur with the view expressed by the music therapist that more dialogue between therapists and teachers would ensure that each knew what the other was doing and therefore not feel mutually threatened (MTh4); this may be defined as *talking with a music therapist.* Thirdly, the opportunity of *working (and planning) with a music therapist* towards a shared objective of, for example, enhancing a pupil's self-esteem as suggested by Michel (1985), was considered to be a realistic way forward by the music educator who wanted to team-teach alongside a therapist (MEd3). And fourthly, the desire expressed by eight of the participants that therapists might work in a consultative capacity with teachers may be defined as *being observed by a music therapist.* This latter form of collaboration would seem to be more firmly established in America as discussed by Chester, Holmberg, Lawrence and Thurmond (1999), Johnson (1996) and Steele (1977).

An example of this consultative approach is given by Nordoff and Robbins (1983) when they write:

> . . . . a skilful teacher or musician with a direct, personal style can create attractive and therapeutic experiences. Our point is that if she were given the right kind of supportive assistance, she could realize more varied and extensive experiences, engage more severely handicapped children, and integrate more children in a group's activity. (p. 19)

It is intriguing to note that, according to Nordoff and Robbins, therapeutic experiences can be created by teachers - i.e. *non*-therapists. While this would be contested today by the Health Professions Council, (due to the legal requirement pertaining to protection of title), there is a willingness on the part of the two authors to promote a consultative role.

Indeed, this particular approach is in keeping with what might be regarded as a therapeutic attitude; that is, the therapist would seek to work *with* the needs and abilities of the teachers rather than impose a dogmatic framework within which teachers should discharge their responsibilities. Ultimately, the beneficiaries are the pupils themselves.

In conclusion, the transdisciplinary nature of music therapy (Bruscia 1998) lends itself naturally to collaborative ways of working. Yet it seems pertinent to note that while the participants widely welcomed a *consultative* relationship, at no point in the interviews was the point made that this might preclude therapists from working in a *directive* way with pupils with special needs. Implicit within this view was the sense that there would always be a population of pupils whose needs were such that the specific clinical intervention of a music therapist was required. There is a correlation here with the claim held by Wilson (1969) that within schools there would always be a need for 'The use of experts' (p. 75). Moreover, as was noted in chapter 2.3.4, while there is scope for the teacher to embrace the notions of health-promoter and sickness-preventer, the role of sickness-remover would seem to be exclusive to the therapist (Combs, 1989). Thus, in theory as well as in practice, a boundary between music education and music therapy will represent a safeguard for the very specific needs of a certain population of pupils. By definition, however, a boundary suggests a general area within which a division requires to be made. And within this division lies the potential for theoretical interdependence between music therapy and music education.

CHAPTER 6 IMPLICATIONS AND CONCLUSION

6.1 Context

The purpose of this chapter is to consider the implications of this thesis based on the combined findings from the review of literature and the responses from interview participants. This will formulate the basis for a conclusion which will seek to both justify and outline the rationale for an educational dimension to music therapy.

At the culmination of the review of literature, it was noted that a degree of theoretical interdependence between music therapy and music education had links with good practice and could therefore lead to the realisation of attainable and desirable practical outcomes. Thus, within the literature reviewed there was evidence of a motivation for theoretical interdependence between the two professions. Similarly, the responses from interview participants indicated that while there were some concerns regarding the form of training music educators might receive in this area, there was a unanimous aspiration for music teachers and music therapists to work more closely together. In addition, music educators expressed a strong willingness to be more informed and skilled with regard to music therapy processes. On this basis, therefore, it seems reasonable to infer from the combined theoretical and empirical findings that sufficient motivation exists for theoretical interdependence between music therapy and music education. Therefore, the formalisation of the concept of educational music therapy would appear to be an appropriate context for this theoretical interdependence.

It is important, however, to acknowledge the limitations of this research and to consider aspects of the process that might have been undertaken differently. A degree of hindsight is always helpful and, from this, suggestions for future research may become apparent. In so doing, the writer is informed of particular areas that require further investigation as well as the choice of research design most appropriate towards the accumulation of subsequent data. For this writer, therefore, the following five areas represent the limitations of this research project:

- There is always more literature that might have been read and reviewed. The writer is aware that the concept of educational music therapy is not entirely new. In 1981 a paper was published in Germany by Kemmelmeyer and Probst entitled *Original Writings about Educational Music Therapy.* This, apparently, was based on the work undertaken by these two authors in Germany in the 1960s. The writer has been unable to locate this paper and is not aware that an English translation exists. In addition, in 1997 the Lithuanian Association for Educational Music Therapy was founded in response to concerns that in educational establishments there were 'gaps in professional and psychological training, lack of literature and special methods for work with the handicapped people' (Aleksiene, 2002, p. 6)(1).

- While the participants who were involved in the interview process represented a diverse range of professional contexts, the actual number who were interviewed (eleven) was quite small. Although the focus of this research was essentially qualitative rather than quantitative, a higher number of participants might have added to the weight of the findings and thereby provided greater substance to the implications.

- It may be argued that the professional acquaintance the writer had with each of the participants resulted in a lack of objectivity. It is possible that had participants been unfamiliar to the writer, it might have been easier for them to be more open and forthright. Having acknowledged this limitation, the writer is also aware that on a number of occasions he was appropriately and constructively challenged on the basis of his own professional practice, experience and views.

(1) This needs to be considered within the context that, in Lithuania, no professional training in music therapy currently exists. Furthermore, it is only within the last fifteen years that a revival in music education for children with special needs has been observed and educational music therapy would appear to be an attempt to address this issue within a relatively informal framework.

- On reflection, the writer feels that the question *How clearly can clinical needs be distinguished from special educational needs?* was slightly ambiguous. For it is the way in which a particular need is met rather than its verbal categorisation that is most important. To this end, the writer believes that the term *clinical interventions* (and *special educational interventions*) would have been more accurate and led to a deeper level of analysis and debate.

- Finally, while this thesis has sought to provide a theoretical analysis towards the conceptualisation of educational music therapy, the writer is aware that issues of practical and professional consequence have not been discussed. The actual implementation of educational music therapy would likely have significant implications with regard to the training *for* and practice *of* music therapy as well as music education. These, however, are issues for further research although it may be claimed that an acknowledgement of practical outcomes would have helped to inform more clearly the theoretical direction that this thesis has taken.

6.2 Implications

The transdisciplinary nature of music therapy and its application within educational settings suggest that there is an environmental framework that would be appropriate for a degree of theoretical interdependence between music therapy and music education. Furthermore, the increasing political and professional emphases on collaborative ways of working between teachers and therapists *in general* appear to be providing a practical motivation for such theoretical interdependence to be made manifest. Similarly, the inclusion of pupils with special educational needs within unified curricular structures, such as the Higher Still programme, indicates an ethical justification for greater theoretical interdependence. And finally, the person-centred dimension implicit within music therapy and music education lends itself favourably to a humanistic rationale for theoretical interdependence between the two professions. Therefore, for environmental, practical, ethical and humanistic reasons, theoretical interdependence between music therapy and music education would appear to serve the interests of pupils with special needs.

A central theme of this argument (indeed of this thesis) is that the specific needs of the individual pupil should determine whether the form of musical intervention to be offered should be predominantly therapeutic or predominantly educational. While for some pupils, the nature of musical engagement will be exclusively therapeutic or exclusively educational, there would seem to be a population of pupils whose needs and abilities are more suited to an educational form of music therapy. This is the underlying rationale for educational music therapy. The concept of educational music therapy would appear to be appropriate for the purpose of defining an approach that is therapeutic in foundation yet educational in direction. The writer proposes that this should be distinct from the concept of clinical music therapy. The apparent absence of a choice of route such as this in current music therapy practice is considered by the writer as a valid reason to delimit in this particular way.

Figure 1

A CONTINUUM MODEL

CLINICAL MUSIC THERAPY		EDUCATIONAL MUSIC THERAPY		MUSIC EDUCATION		MUSIC PROFESSION
SURVIVING	→	SUBCONSCIOUS LEARNING	→	CONSCIOUS LEARNING	→	TRAINING
COPING	→	CONTRIBUTING	→	REFINING	→	WORKING
FUNCTIONING	→	GROWING	→	FOCUSING	→	INFORMING
REACTING	→	RESPONDING (AESTHETIC)	→	RESPONDING (ARTISTIC)	→	PERFORMING

6.2.1 The Case for a Continuum

The writer proposes the continuum model (Figure 1) as a means of presenting the particular position of educational music therapy between clinical music therapy and music education. At the same time, he is keen to emphasise that the *notion* of a continuum is more important than the fixing of a precise terminology at strategic points.

There is also a possibility that too much might be read into the *direction* of this continuum model, as is perhaps reinforced by the arrows pointing only from left to right. It is not the intention that a pupil who has successfully undertaken activities of an educational music therapy emphasis, would automatically move towards a music education programme. Indeed, it may be that the pupil would benefit more from a longer input of educational music therapy, but at a deeper level. Progression, therefore, need not be viewed only from a lateral perspective. Thus, the reader might be aided in perceiving the model as a gradual refinement of possible stages rather than as a singular line of improvement.

As can be observed, the continuum presents the use of music as an intervention in four different ways. These are as follows:

6.2.1.1 *Clinical Music Therapy*

The intervention of clinical music therapy is intended for those pupils whose needs are considered complex, multiple, severe or profound. This may be compared to Bruscia's intensive level in which music therapy takes a 'central and independent role', and also to his primary level in which music therapy 'takes an indispensable or singular role' (1998, p. 163). Further theoretical underpinning may be observed in Combs' perception of therapy as sickness-remover and sickness-preventer (1989) and Maslow's concern that the satisfaction of deficiencies avoids illness and thus ensures survival (1968).

It is proposed that clinical music therapy implies musical intervention is required to assist the pupil to *cope with* the environment and, for whom, the steering of the activity

into more intellectual areas would not be appropriate. The therapist, therefore, is musically interacting with the reactions of the pupil; such reactions may or may not evince deliberate musical intent.

6.2.1.2 *Educational Music Therapy*

The intervention of educational music therapy is intended for those pupils whose needs are considered mild or moderate. This may be compared to Bruscia's augmentative level in which music therapy 'is used to enhance the efforts of other treatment modalities' (1998, p. 163). It may be suggested that this links closely to Combs' perception of therapy as sickness-preventer and health-promoter (1989) and Maslow's statement that 'growth satisfactions produce positive health' (1968, p. 32).

It is proposed that educational music therapy implies musical intervention is required to help the individual to *contribute to* the environment. Thus, while the therapist may commence along therapeutic lines and be working towards the personal well-being of the pupil, a time may come when more specific musical objectives will determine the nature of the activities. This should not be perceived as relinquishing therapy for the sake of teaching; rather, through the process of non-directive teaching, or teaching as an outcome of therapeutic encounter, the well-being of the individual might be enhanced further through educational activity and accomplishment.

Links may be observed here with the sense of context that is central to Community Music Therapy (Pavlicevic and Ansdell, 2004) and culture-centered music therapy (Stige, 2002). Furthermore, from an educational perspective the underlying approach is similar to Regelski's holistic model for music education in which he proposes the refinement of educational steps as an outcome of the initial musical experience (1981, p. 132). Educational music therapy, therefore, may differ from clinical music therapy in that verbal discussion (or discussion by means most appropriate to the needs and abilities of the individual pupil) would be more likely to follow the musical activity. Such discussion might seek to draw the attention of the pupil to particular musical concepts or features that were deployed in the earlier exchange. Later, these could form the basis of future musical

tasks such as a listening or inventing activity related to the initial stimulus. This sensitive implementation of particular concepts may at first be deployed in the therapist's improvisation, leading to the consolidation of *musical response to* rather than *verbal identification of* the chosen concepts on the part of the pupil.

Like Regelski, the writings of Swanwick (1999) and Reimer (1989) promote the need for a musical (aesthetic) experience to be the foundation of subsequent musical learning. Swanwick (1999), for example, emphasises the significance of musical discourse and the importance of 'meaningful interchange' (p. 2) as a result of the practical activity. To this, the writer would add that care for musical discourse *between* therapist and pupil needs to be considered. Furthermore, the reversing of Swanwick's 'music as metaphor' model, thus *beginning* with 'music informs the life of feeling' then 'tunes are heard together in new relationships' and finally 'tones are heard as tunes' (pp. 13-19) would seem to present a basis from which the educational music therapist can move forward.

In principle, the needs of the pupil would determine the nature and level of difficulty of the subsequent tasks, and care would need to be taken to ensure that the aesthetic quality of each activity was not diminished by a drive to heighten cognitive understanding. The process of learning, therefore, is largely subconscious and an outcome of the initial *responding* to the music. Yet the educational dimension to therapy may also be observed when the subconscious response of the pupil is steered into a more conscious awareness of the learning that has taken place. A parallel may be drawn here with cognitive-developmental psychology in music education and the work of Hargreaves (1996). By taking account of Piaget's cognitive as well as developmental emphases in learning processes, Hargreaves believes that this acts as a successful template for the assimilation of musical understanding (p. 54). The transitional procedures that occur as children make sense of their environment can also be observed in their musical thinking. As an example of this, Hargreaves cites the significance of a developmental approach to aesthetic appreciation and how this may link with Piaget's focus on age-related changes within a sequence of stages. While a connection may be noted with the aesthetic dimension of music that is a feature of educational music therapy, special relevance might be attached

to the transition from subconscious responding to conscious learning in this model with Piaget's theory of concrete operations (Wadsworth, 2004).

6.2.1.3 *Music Education*

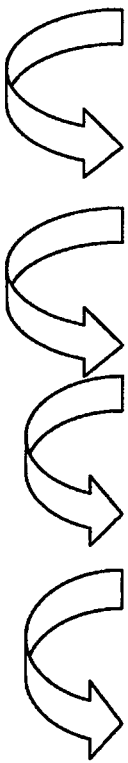
Music education is concerned with the conscious learning of music as a curricular subject (Paynter 1992). As such, it is concerned with the refining of musical skills and seeks to focus more closely on the acquisition of musical knowledge. While still highlighting the significance of the aesthetic response and aspects of learning *through* music, music education will deliberately concentrate on the development of the artistic response and provide opportunities for learning *in* and *about* music. The praxial philosophy of Elliott in which 'Self-growth, self-knowledge, and flow are the central values of MUSIC and, therefore, the central aims of music education.' (1995, p. 259) would seem to complement the opinions discussed earlier of Swanwick and Regelski. Thus, music education may be considered a conscious musical refining of educational music therapy *for those pupils whom it is considered appropriate.*

6.2.1.4 *Music Profession*

The far right of the continuum is concerned with those pupils who may choose to make music their career; that is, music as a professional aspiration and the precise training requirements for the particular field chosen, such as a performer or composer. It is here, too, that the music therapist and the music teacher are professionally situated. While it is not the purpose of this model to demonstrate a logical progression from being a *consumer* of clinical music therapy to becoming a *provider* within the myriad professions of music, it is only those who fulfil the requirements of this final point on the continuum who are then qualified to musically engage with those who comprise the first three points. To an extent, therefore, the continuum represents a continuous cycle of musical interventions.

FIGURE 2

EDUCATIONAL MUSIC THERAPY A SUGGESTED MODEL



STAGE	PROCESS	ACTION
RAW RESPONSE	OBSERVATION	*NOTICING*
PERSONAL PROFILE	REFLECTION	*THINKING*
MUSICAL MEANING	CONSIDERATION	*PLANNING*
INTERACTIVE IMPROVISATION	INTER-RELATION	*DOING*
REFINE RESPONSE	EXAMINATION	*CONFIRMING*

6.3 Conclusion

The educational music therapist, like Goll's special educational music therapist (1994), needs to ensure that the objectives pursued are predominantly educational in nature. However, unlike Goll's model, which is a synthesis of special education and music therapy, educational music therapy is an attempt to combine music education and music therapy.

A suggested framework for educational music therapy is outlined in Figure 2. By adopting this process, the therapist is encouraged to be entirely non-judgmental and thereby begin by observing the *Raw Response* of the pupil when engaged in solitary musical activity. This allows the therapist to notice the pupil's musical tendencies, preferences and needs in a pure form void of interaction with another person. From this, the therapist may begin to build a *Personal Profile* of the pupil acquired through careful analysis and reflection. Further consideration will inform the therapist as to the *Musical Meaning* or implications of the pupil's responses which, in turn, can indicate the nature of the *Interactive Improvisation* that can then follow. At this point, issues of planning may be concerned with the appropriate balance between musical freedom and structure, the accompaniment styles, and the instruments considered most suitable. The final step would be to contemplate how best to *Refine Response*, i.e. through the process of constructive examination, the therapist would wish to confirm or consolidate the musical achievement made and what targets may now be put in place.

In conclusion, the educational music therapist needs to recognise that the ultimate aim is not to cure but to make more secure that which is less secure or insecure. This can be achieved through an appreciation of the therapeutic value of learning, a belief in the power of music to both heal and inform, and faith in the human capacity to react and respond to the careful implementation of the musical experience, and be subsequently renewed.

6.3.1 Coda

The words of Schober and the music of Schubert unknowingly combine to portray the therapeutic *effect* of music. When this is made manifest through personal and creative interaction, the power of music to influence and inform begins to *take* effect. As with Schubert's song, the bringing together of words and music results in a new qualitative experience. Similarly, the bringing together of education and therapy *within* music can be more than a combination of two different forms of intervention; it can be a realisation of a new way of working and, subsequently, a new way of being.

As developments in music education and music therapy incline towards a greater degree of theoretical interdependence, the concept of educational music therapy may be justified. And, in light of this, the special needs of pupils can be better served.

For it is *from music* that our inspirations are found. And, ultimately, it is *to music* that our acknowledgment is made.

An die Musik.

REFERENCES

Achenbach, C. (2002) *Creative Music in Groupwork.* Bicester: Speechmark Publishing Ltd.

Aigen, K. (1995) 'Principles of Qualitative Research'. In B. L. Wheeler (ed.) *Music Therapy Research: Quantitative and Qualitative Perspectives.* Phoenixville, PA: Barcelona Publishers

Aigen, K. (1995a) 'An Aesthetic Foundation of Clinical Theory: An Underlying Basis of Creative Music Therapy'. In C. Kenny (ed.) *Listening, Playing, Creating: Essays on the Power of Sound.* Albany, NY: State University of New York

Aigen, K. (1996) *Being in Music: Foundations of Nordoff-Robbins Music Therapy.* St Louis, Missouri: MMB Music

Aigen, K. (2004) 'Conversations on Creating Community: Performance as Music Therapy in New York City'. In M. Pavlicevic and G. Ansdell (eds.) *Community Music Therapy.* London and Philadelphia: Jessica Kingsley Publishers

Aldridge, D. (ed.) (1999) *Music Therapy in Palliative Care.* London and Philadelphia: Jessica Kingsley Publishers

Aleksiene, V. (March 2002) *Music Therapy in Lithuania: A Brief Review.* http://www.voices.no/country/monthlithuania.html

Alvin, J. (1975) *Music Therapy.* London: Hutchinson

Alvin, J. and Warwick, A. (1991) *Music Therapy for the Autistic Child* (second edition). Oxford: Oxford University Press

Amir, D. (2004) 'Community Music Therapy and the Challenge of Multiculturalism'. In M. Pavlicevic and G. Ansdell (eds.) *Community Music Therapy.* London and Philadelphia: Jessica Kingsley Publishers

Ansdell, G. (2000) *Music for Life.* London and Philadelphia: Jessica Kingsley Publishers

Ansdell, G. (2003) 'Community Music Therapy: Big British Balloon or Future International Trend?'. In *Community, Relationship and Spirit: Continuing the Dialogue and Debate.* London: BSMT Publications

Ansdell, G. (2004) 'Rethinking Music and Community: Theoretical Perspectives in Support of Community Music Therapy'. In M. Pavlicevic and G. Ansdell (eds.) *Community Music Therapy.* London and Philadelphia: Jessica Kingsley Publishers

Ansdell, G. and Pavlicevic, M. (2006) *Beginning Research in the Arts Therapies.* London and Philadelphia: Jessica Kingsley Publishers

Association of Professional Music Therapists (2002a) *A Career in Music Therapy.* UK: APMT

Association of Professional Music Therapists (2003) 'A.P.M.T. Code of Professional Ethics and Conduct'. *Information.* East Barnet: APMT

Bailey, P. (1974) *They Can Make Music.* London: Oxford University Press

Bean, J. and Oldfield, A. (1991) *Pied Piper: Musical Activities to Develop Basic Skills.* Cambridge: Cambridge University Press

Best, D. (1992) *The Rationality of Feeling.* London and Washington, DC: The Falmer Press

Bloomer, K. (2003) 'The Local Governance of Education: A Political Perspective'. In T.G.C. Bryce and W.M. Humes (eds.) *Scottish Education* (second edition: Post-Devolution). Edinburgh: Edinburgh University Press

Boyce-Tillman, J. (2000) *Constructing Musical Healing.* London and Philadelphia: Jessica Kingsley Publishers

Brandt, G., Wohler, D. and Aldridge, D. (1991) 'Working Together: A Comparative Study of Music Therapy and Art Therapy'. *Journal of British Music Therapy* 5(1):14-21

Brewer, B. (2003) 'Physical Education and Sport'. In T.G.C. Bryce and W.M. Humes (eds.) *Scottish Education* (second edition: Post-Devolution). Edinburgh: Edinburgh University Press

Bright, R. (1991) *Music in Geriatric Care: A Second Look.* Wahroonga: Music Therapy Enterprises

Bruscia, K.E. (1998) *Defining Music Therapy* (second edition). Gilsum NH: Barcelona Publishers

Bunt, L. (1994) *Music Therapy: An Art Beyond Words.* London and New York: Routledge

Bunt, L. and Hoskyns, S. (eds.) (2002) *The Handbook of Music Therapy.* East Sussex: Brunner-Routledge

Burridge, P. (Summer 2000) *Harnessing Dreams.* Times Educational Supplement Curriculum Special

Chester, K.K., Holmberg, T.K., Lawrence, M.P. and Thurmond, L.L. (1999) 'A Program-based Consultative Music Therapy Model for Public Schools'. *Music Therapy Perspectives* 17(2):82-91

Codding, P. (1982) *Music Therapy for Handicapped Children: Visually Impaired.* Washington, DC: National Association for Music Therapy

Colebatch, H.K. (1998) *Policy.* Buckingham: Open University Press

Coleman, K.A. (1996) 'Music Therapy for Learners with Severe Disabilities in a Public School Setting'. In B.L. Wilson (ed.) *Models of Music Therapy Interventions in School Settings: From Institution to Inclusion.* Silver Spring, MD: The American Music Therapy Association, Inc.

Combs, A.W. (1989) *A Theory of Therapy: Guidelines for Counseling Practice.* California: Sage Publications, Inc.

Committee of Enquiry into the Education of Handicapped Children and Young People (1978) *Special Educational Needs* (The Warnock Report). London: HMSO

Cook, N. (2000) *Music: A Very Short Introduction.* Oxford: Oxford University Press

Cooke, D. (1981) *The Language of Music.* Oxford: Oxford University Press

Csikszentmihalyi, M. (1993) *The Evolving Self: A Psychology for the Third Millennium.* New York: HarperCollins

Csikszentmihalyi, M. and Csikszentmihalyi, I. (eds.) (1988) *Optimal Experience: Psychological Studies of Flow in Consciousness.* Cambridge: Cambridge University Press

Darrow, A. (1996) 'Research on Mainstreaming: Implications for Music Therapists'. In B.L. Wilson (ed.) *Models of Music Therapy Interventions in School Settings: From Institution to Inclusion.* Silver Spring, MD: The American Music Therapy Association, Inc.

Davies, A. and Richards, E. (2002) *Music Therapy and Group Work: Sound Company.* London and Philadelphia: Jessica Kingsley Publishers

Dawes, R.M. (1994) *House of Cards: Psychology and Psychotherapy Built on Myth.* New York: The Free Press

Department for Education and Employment (1997) *Excellence for all Children - Meeting Special Educational Needs.* London: DfEE

Dewey, J. (1938) *Experience and Education.* Kappa Delta Pi. Published in arrangement with U.S.A.: Touchstone (Simon & Schuster) 1997

Dobbs, J.P.B. (1966) *The Slow Learner and Music.* London: Oxford University Press

Drever, E. (1995) *Using Semi-Structured Interviews in Small-Scale Research - A Teacher's Guide.* Edinburgh: The Scottish Council for Research in Education

Duerksen, G.L. (1967) 'Some Similarities Between Music Education and Music Therapy'. *Journal of Music Therapy* 4(3):95-99

Elliott, D. (1995) *Music Matters.* New York and Oxford: Oxford University Press

Farnan, L.A. (1996) 'Music Therapy for Learners with Severe Disabilities in a Residential Setting'. In B.L. Wilson (ed.) *Models of Music Therapy Interventions in School Settings: From Institution to Inclusion.* Silver Spring, MD: The American Music Therapy Association, Inc.

Finney, J. (1999) 'The Rights and Wrongs of School Music: Considering the Expressivist Argument and its Existential Component'. *British Journal of Music Education* 16(3):237-44

Forbes, J.C. (2001) 'Teacher/Therapist Collaboration Policy: An Analysis'. *Child Language Teaching and Therapy* 17(3):195-205

Forum For The Advancement of Educational Therapy and Therapeutic Teaching (1997) *Information Leaflet.* FAETT

Fuller, P. (1996) 'Foreword'. In T. Dalley (ed.) *Art as Therapy.* London and New York: Routledge

Furedi, F. (2004) *Therapy Culture.* London and New York: Routledge

Gardner, H. (1993) *Frames of Mind* (second edition). London: Fontana Press

Gascho-White, W. (1996) 'Music Therapy and Music Education: Our Common Ground; Our Separate Paths'. *Canadian Music Educator* 38(1):33-5

Gaston, E.T. (ed.) (1968) *Music in Therapy.* New York: Macmillan

Goldsmiths College (1999) *Postgraduate Prospectus.* London: Goldsmiths College, University of London

Goleman, D. (1996) *Emotional Intelligence.* London: Bloomsbury

Goll, H.H. (1994) *Special Educational Music Therapy with Persons who have Severe/Profound Retardation.* Frankfurt am Main: Peter Lang

Graham, G. (1998) *Philosophy of the Arts: An Introduction to Aesthetics.* London and New York: Routledge

Griggs-Drane, E.R. (1996) 'Implications for Contractual Employment and Private Practice'. In B.L. Wilson (ed.) *Models of Music Therapy Interventions in School Settings: From Institution to Inclusion.* Silver Spring, MD: The American Music Therapy Association, Inc.

Hargreaves, D. (1996) 'The Developmental Psychology of Music: Scope and Aims'. In G. Spruce (ed.) *Teaching Music.* London: Routledge

Heine C.C. (1996) 'Inservice Training: A Major Key to Successful Integration of Special Needs Children into Music Education Classes'. In B.L. Wilson (ed.) *Models of Music Therapy Interventions in School Settings: From Institution to Inclusion.* Silver Spring, MD: The American Music Therapy Association, Inc.

Her Majesty's Inspectorate of Schools Report (1996) *The Education of Pupils with Language and Communication Disorders.* Edinburgh: HMSO

Higher Still Development Unit (1997) *Higher Still Arrangements for Music.* Edinburgh: Scottish CCC

Hirsch, Jr. E.D. (1999) *The Schools We Need and Why We Don't Have Them.* U.S.A.: Anchor Books

Hirst, P.H. and Peters, R.S. (1980) *The Logic of Education.* London and Henley: Routledge & Kegan Paul

Holden, A. (1969) *Teachers as Counsellors.* London: Constable

Isern, B. (1964) 'Music in Special Education'. *Journal of Music Therapy* 1(4):139-42

Jellison, J.A. (1979) 'The Music Therapist in the Educational Setting: Developing and Implementing Curriculum for the Handicapped'. *Journal of Music Therapy* 16(3):128-137

Johnson, F.L. (1996) 'Models of Service Delivery'. In B.L. Wilson (ed.) *Models of Music Therapy Interventions in School Settings: From Institution to Inclusion.* Silver Spring, MD: The American Music Therapy Association, Inc.

Kelman, H.C. (1972) 'The Rights of the Subject in Social Research: An Analysis in Terms of Relative Power and Legitimacy'. *American Psychologist* 27, 989-1016

Kemmelmeyer, K.J. and Probst, W. (1981) *Quellentexte zur Padagogischen Musiktherapie* [Original Writings about Educational Music Therapy]. Regensburg: Bosse

Kiger, A.M. (1997) *Teaching for Health* (second edition). Edinburgh: Churchill Livingstone

Krout, R. (1986) *Music Therapy in Special Education: Developing and Maintaining Social Skills Necessary for Mainstreaming.* St Louis, MO: MMB Music, Inc.

Kvale, S. (1996) *InterViews.* California: Sage Publications, Inc.

Kwami, R. (1996) 'Music Education In and For a Multi-Cultural Society'. In C. Plummeridge (ed.) *Music Education: Trends and Issues.* London: Institute of Education

Laing, J. (1996) 'Art Therapy in Prisons'. In T. Dalley (ed.) *Art as Therapy.* London and New York: Routledge

Lane, M.W. and Joyner, R. (1999) 'Stepping Outside the Box: Music Therapists in a Music Education Setting'. Unpublished handout presented at the *9th World Congress of Music Therapy, 1999.* Washington, DC

Lasch, C. (1991) *The Culture of Narcissism.* New York and London: W. W. Norton and Company

Lee, C.A. (2003) *The Architecture of Aesthetic Music Therapy.* Gilsum NH: Barcelona Publishers

Leite, T. (2002) Music Therapy for Educators: Are we Informing or Training?'. Unpublished paper presented at the *10th World Congress of Music Therapy, 2002.* Oxford

MacKay, G. and McLarty, M. (2003) 'Educational Support for Children with Disabilities'. In T.G.C. Bryce and W.M. Humes (eds.) *Scottish Education* (second edition: Post-Devolution). Edinburgh: Edinburgh University Press

MacKay, T. (2003) 'Psychological Services and their Impact'. In T.G.C. Bryce and W.M. Humes (eds.) *Scottish Education* (second edition: Post-Devolution). Edinburgh: Edinburgh University Press

Mackenzie, J. (2003) 'Disaffection with Schooling'. In T.G.C. Bryce and W.M. Humes (eds.) *Scottish Education* (second edition: Post-Devolution). Edinburgh: Edinburgh University Press

Mac Laverty, B. (1997) *Grace Notes.* London: Jonathan Cape

Mandyczewski, E. (ed.) (1985) *Fifty-nine Favourite Songs by Franz Schubert.* New York: Dover Publications, Inc.

Maratos (2004) 'Whatever Next? Community Music Therapy for the Institution!'. In M. Pavlicevic and G. Ansdell (eds.) *Community Music Therapy.* London and Philadelphia: Jessica Kingsley Publishers

Maslow, A. (1968) *Toward a Psychology of Being* (second edition). New York and Cincinnati: D. Van Nostrand Company

Maykut. P. and Morehouse, R. (1994) *Beginning Qualitative Research.* London: Falmer

McGuire, M.G. (1995) 'Writing the Research Report'. In B. L. Wheeler (ed.) *Music Therapy Research: Quantitative and Qualitative Perspectives.* Phoenixville, PA: Barcelona Publishers

McLaren, D.J. (2003) 'Guidance, Personal and Social Education and Pastoral Care in the Secondary School'. In T.G.C. Bryce and W.M. Humes (eds.) *Scottish Education* (second edition: Post-Devolution). Edinburgh: Edinburgh University Press

Michel, D.E. (1985) *Music Therapy.* Illinois: Charles C. Thomas

Milburn, T. and Wallace, D. (2003) 'Community Education, Community Learning and Development'. In T.G.C. Bryce and W.M. Humes (eds.) *Scottish Education* (second edition: Post-Devolution). Edinburgh: Edinburgh University Press

Morton, G. (2000) 'Educational Therapy: Challenges and Possibilities of Work in Different Settings'. *Educational Therapy and Therapeutic Teaching* 9:39-57

Nordoff, P. and Robbins, C. (1969) *Pif-Paf-Poltrie.* Pennsylvania: Theodore Presser Company

Nordoff, P. and Robbins, C. (1977) *Creative Music Therapy.* New York: The John Day Company

Nordoff, P. and Robbins, C. (1983) *Music Therapy in Special Education.* St Louis, MO: Magnamusic-Baton

Norrie, K.M. (1998) *Children (Scotland) Act 1995* (revised edition). Edinburgh: W. Green/Sweet & Maxwell

North, A.C., Hargreaves, D.J. and O'Neill, S. (2000) 'The Importance of Music to Adolescents'. *British Journal of Educational Psychology* 70:255-72

O'Callaghan, C. (2005) 'Songs Written by Palliative Care Patients in Music Therapy'. In C.A. Lee (ed.) *Lonely Waters: Proceedings of the International Conference 'Music Therapy in Palliative Care', Oxford, 1994.* Oxford: Sobell Publications

Odam, G. (1995) *The Sounding Symbol.* Cheltenham: Stanley Thornes (Publishers) Ltd.

Pavlicevic, M. (1985) 'Music as Therapy: Towards an Integrated Experience'. *British Journal of Music Education* 2(2):153-58

Pavlicevic, M. (1997) *Music Therapy in Context.* London and Philadelphia: Jessica Kingsley Publishers

Pavlicevic, M. (2003) *Groups in Music - Strategies from Music Therapy.* London and New York: Jessica Kingsley Publishers

Pavlicevic, M. and Ansdell, G. (eds.) (2004) *Community Music Therapy.* London and Philadelphia: Jessica Kingsley Publishers

Paynter, J. and Aston, P. (1970) *Sound and Silence.* London: Cambridge University Press

Paynter, J. (1972) *Hear and Now.* London: Universal Edition Ltd.

Paynter, J. (1992) *Sound and Structure.* Cambridge: Cambridge University Press

Perry, T.M. (1995) *Music Lessons for Children with Special Needs.* London and Bristol, Pennsylvania: Jessica Kingsley Publishers

Powell, H. (2004) '*A Dream Wedding*: From Community Music to Music Therapy with a Community'. In M. Pavlicevic and G. Ansdell (eds.) *Community Music Therapy.* London and Philadelphia: Jessica Kingsley Publishers

Pratt, R.R. (1995) 'Music Therapy and Special Music Education: Interdisciplinary Research and Clinical Practice within the Fields of Medicine and Psychotherapy'. In R.R. Pratt (ed.) *Music Therapy and Music Education for the Handicapped.* Saint Louis, MO: MMB Music

Regelski, T.A. (1981) *Teaching General Music.* New York: Schirmer Books

Reiff, P. (1987) *The Triumph of the Therapeutic.* Chicago and London: The University of Chicago Press

Reimer, B. (1989) *A Philosophy of Music Education* (second edition). NJ: Prentice-Hall, Inc.

Robbins, C. and Robbins C. (1980) *Music for the Hearing Impaired and Other Special Groups.* St Louis, MO: MMB Music, Inc.

Robbins, C. and Robbins, C. (eds.) (1998) *Healing Heritage: Paul Nordoff Exploring the Tonal Language of Music.* Gilson NH: Barcelona Publishers

Robertson, J. (2000) 'An Educational Model for Music Therapy: The Case for a Continuum'. *British Journal of Music Therapy* 14(1):41-6

Rogers, C.R. (1998) *Client-Centered Therapy.* London: Constable

Ross, M. (1984) *The Aesthetic Impulse.* Oxford: Pergamon Press

Ruud, E. (1998) *Music Therapy: Improvisation, Communication and Culture.* Gilson NH: Barcelona Publishers

Schalkwijk, F.W. (1994) *Music and People with Developmental Disabilities.* London: Jessica Kingsley Publishers Ltd.

Schizophrenia.com Special Report (2006) *What Is It?* http://www.schizophrenia.com/family/sz.overview.htm

Scottish Executive (2002) *Let's Make Scotland more Active - A Strategy for Physical Activity - a consultation.* Physical Activity Task Force

Scottish Office Education Department (1980) *The Education (Scotland) Act.* Edinburgh: SOED

Scottish Office Education Department (1992) *National Guidelines: Expressive Arts 5-14.* Edinburgh: HMSO

Scottish Office Education Department (1994) *Effective Provision for Special Educational Needs (EPSEN).* Edinburgh: SOED

Scottish Office Education and Industry Department (1999) *A Manual of Good Practice in Special Educational Needs.* Edinburgh: SOEID

Sloboda, J. and Davidson, J. (1996) 'The Young Performing Musician'. In I. Deliege and J. Sloboda (eds.) *Musical Beginnings: Origins and Development of Musical Competence.* Oxford: Oxford University Press

Small, C. (1987) *Music of the Common Tongue: Survival and Celebration in Afro-American Music.* New York: Riverrun Press

Sotto, E. (1995) *When Teaching Becomes Learning.* London and New York: Cassell

Spradley, J. (1979) *The Ethnographic Interview.* New York: Holt, Reinhart and Winston

Steele, A.S. (1977) 'Directive Teaching and the Music Therapist as Consultant'. *Journal of Music Therapy* 14(1):17-26

Steiner, R. (1983) *The Inner Nature of Music and the Experience of Tone: Selected Lectures from the Work of Rudolf Steiner.* London: Rudolf Steiner Press

Stige, B. (2002) *Culture-Centered Music Therapy.* Gilsum NH: Barcelona Publishers

Stige, B. (2003) 'Elaborations towards a notion of Community Music Therapy'. *Unpublished PhD Thesis.* Department of Music and Theatre: University of Oslo

Storr, A. (1992) *Music and the Mind.* New York: Ballantine Books

Strange, J. (1987) 'The Role of the Music Therapist in Special Education'. *Journal of British Music Therapy* 1(2):28-31

Swanwick, K. (1995) *Music, Mind, and Education.* London: Routledge

Swanwick, K. (1996) *A Basis for Music Education.* London: Routledge

Swanwick, K. (1999) *Teaching Music Musically.* London: Routledge

Trevarthen, C. (1997) 'Music and Infant Interaction'. *Nordic Journal of Music Therapy* 6(1)

Turry, A. (2001) 'Performance and Product: Clinical Implications for the Music Therapist'. musictherapyworld.net

Wadsworth, B.J. (2004) *Piaget's Theory of Cognitive and Affective Development: Foundations of Constructivism.* University of Toledo: Allyn and Bacon

Waller, D. (1996) 'A Consideration of the Similarities and Differences between Art Therapy and Art Teaching'. In T. Dalley (ed.) *Art as Therapy.* London and New York: Routledge

Welch G., Ockleford, A. and Zimmermann, S. (2001) *Provision of Music in Special Education (PROMISE).* London: IoE University of London and RNIB

Wengrower, H. (2001) 'Arts Therapies in Educational Settings: An Intercultural Encounter'. *The Arts in Psychotherapy* 28(2):109-115

Wheeler, B.L. (1995) *Music Therapy Research: Quantitative and Qualitative Perspectives.* Phoenixville, PA: Barcelona Publishers

Wigram, T. (2004) *Improvisation - Methods and Techniques for Music Therapy Clinicians, Educators and Students.* London and Philadelphia: Jessica Kingsley Publishers

Wigram, T., Pedersen, I.N. and Bonde, L.O. (2002) *A Comprehensive Guide to Music Therapy.* London and Philadelphia: Jessica Kingsley Publishers

Wills, P. and Peter, M. (1996) *Music for All: Developing Music in the Curriculum with Pupils with Special Educational Needs.* London: David Fulton Publishers

Wilson, B.L. (ed.) (1996) *Models of Music Therapy Interventions in School Settings: From Institution to Inclusion.* Silver Spring, MD: The American Music Therapy Association, Inc.

Wilson, J. (1969) *Education and the Concept of Mental Health.* London: Routledge & Kegan Paul

Wilson, S. (1991) 'Music Therapy in Education'. *Journal of British Music Therapy* 5(2):14-7

Witkin, R.W. (1974) *The Intelligence of Feeling.* London: Heinemann Educational Books

Wood, M. (1982) *Music for Living.* Kidderminster: British Institute of Mental Handicap

Wood, M. (1983) *Music for Mentally Handicapped People.* London: Souvenir Press

Wood, S., Verney, R. and Atkinson, J. (2004) 'From Therapy to Community: Making Music in Neurological Rehabilitation'. In M. Pavlicevic and G. Ansdell (eds.) *Community Music Therapy.* London and Philadelphia: Jessica Kingsley Publishers

Woodward, S. (2000) 'A Response to James Robertson's "An Educational Model for Music Therapy: The Case for a Continuum"'. *British Journal of Music Therapy* 14(2):94-8

Zharinova-Sanderson, O. (2004) 'Promoting Integration and Socio-cultural Change: Community Music Therapy with Traumatised Refugees in Berlin'. In M. Pavlicevic and G. Ansdell (eds.) *Community Music Therapy.* London and Philadelphia: Jessica Kingsley Publishers

APPENDIX 1

QUESTIONS FOR PILOT INTERVIEW

What do you consider to be the essential characteristics of music therapy?

What do you consider to be the essential characteristics of music education?

Do you feel that there are areas of commonality between the two professions? If so, what are these areas?

Do you feel that there are fundamental differences between the two professions? If so, what do you consider them to be?

Music therapists often seek to distinguish what they do by referring to the word 'clinical' - e.g. meeting clinical needs, having clinical aims, using clinically directed improvisation. Do you feel, however, that there is clarity of thought between what are perceived to be clinical needs in comparison to special educational needs?

Within the educational sector, do you consider that there are particular types of need (or kinds of children) who should be attended to by a music therapist rather than a music teacher - even if the teacher has had some training in this field (on an in-service or modular basis, for example)?

Who do you feel should determine which needs (if not all) should be met by the music teacher and/or the music therapist - e.g. the music teacher him/herself, the Head teacher, the educational psychologist, the parents?

Due to an increasing emphasis on policies of inclusion, it would seem essential that both future and current teachers of music are given training as how best to work with pupils who have special educational needs. Do you have particular views as to what form this training should take? Who should deliver such input? Should there be a minimum amount of time allocated? Should there be procedures for supervision following successful completion of study?

Do you think that music therapists and music teachers would benefit from working more closely together? Would you welcome, for example, the therapist acting in a consultative capacity with music teachers who are working with pupils who have special needs?

Do you believe that music therapists would be concerned to see teachers take on responsibilities of a more therapeutic dimension, as this could ultimately lead to fewer therapists being required? Taking this to its extreme, do you think that new music therapy posts would be less likely to be created if schools and education authorities considered that teachers could undertake these responsibilities to a satisfactory standard?

The implementation of Access Level within the forthcoming Higher Still programme will mean that those pupils with even the most complex and profound needs will, literally, have access to Higher Still units of work and assessment procedures. This means that

music teachers (as well as teachers in special schools who have a particular skill or interest in music) will now be required to provide such units of work. Do you welcome this? Are you excited by this? Do you think that this in the best interests of the pupils?

Which do think should be given the highest priority: the development of more postgraduate courses in music therapy (as in Nordoff-Robbins, for example) or the introduction of more training opportunities for music teachers to provide them with the skills and experience necessary to work effectively in the special needs' field?

APPENDIX 2

LETTER SENT TO PROSPECTIVE INTERVIEW PARTICIPANTS

4 May 1999

NAME AND ADDRESS OF PERSON

Dear

I have recently embarked on a research degree with the Open University (in association with Northern College) to examine the commonalities and differences between music therapy and music teaching. The intention of this research is to consider the possibility of establishing a new conceptual approach which can be adopted by music teachers working in the special needs field. With the implementation of the Higher Still Programme in Scotland to take place this year (which requires pupils who have special needs to be involved in music education programmes) it is important, I believe, that research in this area is undertaken.

I am hoping, as part of the methodology, to interview a range of people associated with the fields of music therapy and/or music education. This includes practitioners, students and directors of training courses. This may also involve observing a selection of people in their areas of work which could then form the basis of discussion with other participants.

I am writing, therefore, to ask if you would be interested to take part in this research project. The intention would be to conduct the interviews and collect data over the next 12 to 18 months. If you were willing to be involved, the next step would be to meet informally to discuss in more detail the various procedures and format which we might negotiate. It is essential that all who do agree to participate are happy with the requirements which could be made of them and the possible amount of time which may be necessary to invest; I am only too aware of the many demands which are made on people's time in addition to their actual work.

In the meantime, *name of person*, I would be most grateful if you could give this some thought (please telephone me if you require any more information) and return the attached slip by 1 June. A stamped addressed envelope is enclosed.

Yours sincerely

James Robertson
Lecturer in Music (Tel. 01224 283510)

APPENDIX 3

REPLY SLIP ATTACHED WITH LETTER SENT TO PROSPECTIVE INTERVIEW PARTICIPANTS

PARTICIPATION IN RESEARCH PROJECT: MUSIC THERAPY & MUSIC EDUCATION

Name

Address

Contact telephone number (if participating)

Please delete as appropriate:

*I would be interested to take part in the above research project**

I would not be interested to take part in the above research project

*If you are interested you may wish to give preferred dates when you would be available for interview.

Please return by 1 June in the enclosed s.a.e.

Thank you.

APPENDIX 4

TRANSCRIPT OF INTERVIEW WITH MUSIC EDUCATOR

REF. **MEd1**

DATE **13 JANUARY 2000**

VENUE **MUSIC DEPARTMENT IN A SECONDARY SCHOOL**

DURATION **50 MINUTES**

This particular person is a former BEd (Hons) Music student of *name of institution.* She graduated in 1993 and has since worked as a music teacher in a secondary school. For the last two years she has been the Principal teacher of the department. This school is also a base for pupils with special educational needs and she works regularly with these children. In her final year at *name of institution* she chose to do a music therapy topic for her dissertation; this required her to observe a music therapist for several months.

I Interviewer
MEd1 Music Educator

I What do you consider to be the essential characteristics of music education?

MEd1 I think it's essential that every pupil coming through school has a positive musical experience.

I As a music teacher in a secondary school, what are the kinds of aims that you are most frequently working towards?

MEd1 To create a pleasant experience for the pupils to come into. To encourage confidence amongst the youngsters which will then have a knock-on effect in other subjects, perhaps the more academic subjects. We're not thinking about grades and exam passes, we're thinking about the whole experience. For example, we had a school show just before Christmas with over 100 pupils; whereas in the department we have room for a maximum of 20 pupils to sit Standard Grade because of staffing. So we are looking to include as many pupils as possible and just give them a musical experience. That's my priority.

I So you find that musical aims become secondary to the positive experience you want the pupils to have, that the emphasis is on *feeling*?

MEd1 I think so. This is the 'feelgood' department! How pupils feel within themselves is so important. I always remember one pupil who left school two years ago; when I came here at first she was in 2nd year. When she came to music she couldn't even look at me when I spoke to her, she always spoke to you with her head down. She had no confidence. However, she opted to do Standard Grade Music. She wasn't a very able pupil but I noticed that at lunchtimes she would escape from the playground area and come to the music department. She didn't really come to develop her musical talent; she came because it was a room to herself, she was a loner in many ways. But through this she worked really hard and improved. She played keyboard and tuned percussion. By the time she left school in 6th year I had never seen such a change in a pupil. She had completely blossomed, she was actually being cheeky to me! There was an incredible change in her personality, she was more outgoing. I can't say that this was all down to music but it really helped. This happens to so many pupils, those who sing in the choir, for example. Yes, I would be wrong to say that I don't care about exam results, you do have to

have these targets to work towards but I think they are secondary to the whole personality thing. I'm not sure if that is the right way to look at it or not, but. . .

I You're looking at personal and social development, aren't you, as well as musical development?

MEd1 Yes, and also interaction; with this particular pupil she moved from being a loner to becoming one of the 'in crowd'. She had made it, socially, and it was so good to see. She'll not look back with dread on her school days.

I I'm sure that this will continue for her.

MEd1 Yes, although it's not the same for everyone. There will be some who will come and walk away with very little. But I think they are the minority.

I On average, how many pupils do you see in a week?

MEd1 Between us, my assistant and I see between 400 and 500 pupils each week, about half of the school roll. We see the entire 1st and 2nd year and about half of the 3rd and 4th years. What is really nice is that we also see pupils coming into the department, not in a class situation, but those who have done Standard Grade and are not going on to Higher. . . they come back and spend free periods in the department as they have access to all the facilities.

I What do you consider to be the essential characteristics of music therapy, or the aims that a music therapist might have?

MEd1 Similar to what I've just talked about. Therapists are working at developing self-confidence through skills. But I'm not very sure about the aims that a therapist might have.

I Obviously you are working with many more pupils than a therapist but you do seem to also be working towards developing self-confidence, personal and social skills etc.?

MEd1 I see this not only with mainstream pupils but also with those from the S.E.N. base who come to the department. It might be, for example, something very simple, like a 'Hello' song at the start, but now when they pass you in the corridor they say "hello" to you. They wouldn't have done this before.

I So you're seeing the fruits of your labours outwith the music room?

MEd1 Yes. There is one boy, for example, who when he first came from the base never spoke. He would hum and sing songs all the time, his pitch was excellent. Yet he would never hum when I was playing the piano; he would stop, so we would never be playing and humming together. We worked on this. Now he will sing his name as part of "Hello, *name of pupil*" *(she demonstrates by singing).* I will sing "Hello - " and he will sing "*name of pupil*". So he is now using his name. This took two years to achieve; progress is slow but this is a huge step for him.

I It's interesting that you are using musical techniques, concepts and ideas to develop these non-musical aims.

MEd1 That's right.

I From what you have seen and read and heard about music therapy, do you feel that there are fundamental differences between the two professions?

MEd1 Yes, obviously the approach taken by a therapist will require them to work much deeper; working with the character of that particular person. Whereas in education you tend to be skimming the surface, yes you are developing their

personality but you're not getting too personal with the pupils. It's always a difficult area. I'm conscious of it when I'm working with the pupils that I'm not doing anything that is going to harm them by kind of probing around. You don't have to worry about the pupils in mainstream because you can say something to a pupil in mainstream and - that's it. You've got to use other methods when you are working with pupils with special needs. It's a concern I have that I'm not doing any harm because I've had no training. I know that therapists have had a lot of training and know exactly what to do to get a result; whereas I don't and it's very much trial-and-error.

I Yet I think a lot of therapists would say that much of their work is intuitive; that they are observing and listening to a pupil, and then making decisions based on what they *feel*. Therapists, too, can be uncertain and use trial-and-error. Clearly, there are many people - like yourself - who are concerned that they are not doing any harm. But I think it would be very difficult to do harm because your approach is based on goodwill; of wanting to be of help to someone. I am sure that that in itself is only going to do good.

MEd1 There is one situation that seems to reappear: the group from the special needs base comes to music immediately before lunchtime. They have their lunch in the dining room with the rest of the school. There is one particular pupil who comes to music and by the time he leaves he's screaming his head off with excitement, he has had a great time. But he's so worked up that he is very difficult to control while he's eating his lunch. And I walk through at lunchtime and think, "Oh know, that's my fault!". I've tried recently to take him away towards the end of the session - into a small practice room with one of the auxiliaries. And we work at the piano, he's very aggressive, he just wants to thump everything, he's very tense. We sit him at the top end of the piano. What can I do to calm him down? I can't eliminate him from the class! It's having an effect on him. It's these kinds of things that I'm not experienced in.

It's issues such as these where I feel I need some guidance. Yes, they are having an enjoyable musical experience; it's good fun and I am seeing progress. For the first few months I thought I was banging my head against a brick wall and nothing was happening. But now I've stopped thinking like this. The fact that the pupil I mentioned earlier will now sing along with the piano, we'll have interaction; I'll play a bit and then say to him, "It's your turn", he continues the song. I think this is wonderful. We've made videos of this and sent them to the parents. They are just delighted to see this. It's so rewarding. But it's taken a few years to get there. What's so difficult is having to cope with such versatile needs in half an hour for once a week!

I That's interesting and it feeds nicely into the next area. Music therapists often seek to distinguish what they do by referring to the word 'clinical' - e.g. meeting clinical needs, having clinical aims, using clinically directed improvisation. Do you feel, however, that there is clarity of thought between what are perceived to be clinical needs in comparison to special educational needs?

MEd1 I've never used the term 'clinical needs'. What is an example of clinical needs?

I This is something I am trying to find out myself. Perhaps the word 'clinical' is an analogy of the word 'medical'?

MEd1 Yes, that's how I would understand it. But I don't think there can be a definite division between the two. It's not as plain and simple as that.

I Within the educational sector, do you consider that there are particular types of need, or kinds of children, who should be attended to by a music therapist rather than a music teacher - even if the teacher has had some training in this field - on an in-service or modular basis, for example?

MEd1 I don't think so at all. I can always have an input. I can always do something beneficial. Whether the needs are clinical or educational, I don't think that's important to me. Although we have a wide spectrum of needs in the group, I actually feel more comfortable working with those whose needs are more severe. Yes, I feel that I don't know enough to 'dive deep' but I still believe I can do something beneficial.

I So you're not saying that there is a certain population *only* for music therapists.

MEd1 No, I don't think so. But I feel that if you are to work with pupils whose needs are severe then it is best if you have worked with those whose needs are not so severe before. A new teacher coming into the profession would probably not know where to begin if they had not already done some work like this before. A lot of music teachers have not had the chance that I had when I was at college - to observe a music therapist, for example.

I Due to an increasing emphasis on policies of inclusion, it would seem essential that both future and current teachers of music are given some training as how best to work with pupils who have special educational needs. Do you have particular views as to what form this training should take? Who should deliver such input? Should there be a minimum amount of time allocated? Should there be procedures for supervision following successful completion of study?

MEd1 Yes, I strongly believe that students should have a certain amount of time for observation. Not necessarily a music therapist working with special needs, but perhaps an experienced teacher who has worked in this area. I also believe that, following observation, the students should have the opportunity to work with the children themselves. What we are finding is that probationary teachers are suddenly having to deal with special needs pupils. They really have to be prepared for this. There should be more input given to music students than is currently available - and it should be compulsory. The work that you do with these pupils can still be related to the work with mainstream pupils.

I Could you give me an example of this?

MEd1 Even in the mainstream class you are always going to have somebody who is less able. The opportunities I had at college [re music therapy] have helped me to be more patient when working with less able pupils. The ways in which I communicate have also been influenced by this.

I What about your own musical development and skills?

MEd1 Well, that's been put to the test! Improvising, for example. Not necessarily on the piano but because I am a pianist I feel I can express myself best on the piano. Having the freedom and the courage to improvise is important. Improvising is not for everyone. I had certainly not thought about improvising myself until I was put in this position.

I And perhaps the different focus of improvisation?

MEd1 That's right. Having to follow somebody else, not leading. In mainstream classes the pupils will do what I want them to do. Whereas it's very different with special needs; I've got to be ready to change with the pupil. That's kept me on my toes - and also having to play while not looking at my hands!

I Would you like, in mainstream, to not have to lead so much?

MEd1 In an ideal world, yes, but in reality it just doesn't happen - timewise. There are the expectations, the targets, the concepts to be covered. I really disagree with this philosophy of concepts - from 1st year straight through to Higher. It's forced upon us. There's one unit I do with the 1st year pupils, a vocalising unit based on

Berio's *Sequenza 3*. At the end of the unit they have to produce a vocal composition. But I don't base it on concepts - as such. Yet it works, and they are composing! It's creative. But the concept-based criteria makes it difficult to assess.

I Do you think that music therapists and music teachers would benefit from working more closely together? Would you welcome, for example, the therapist acting in a consultative capacity with music teachers who are working with pupils who have special needs?

MEd1 Yes. This could be modelled on the visiting music specialist idea where you might have a professional music therapist based in the region but travelling round several schools. They could give you so many ideas and then you could say, "Fine, you can leave me now, I'll see you again in a few weeks". This would give me the confidence to do a little bit more than what I am doing.

I Do you believe that music therapists would be concerned to see teachers take on responsibilities of a more therapeutic dimension, as this could ultimately lead to fewer therapists being required? Taking this to its extreme, do you think that new music therapy posts would be less likely to be created if schools and education authorities considered that teachers could undertake these responsibilities to a satisfactory standard?

MEd1 It's a difficult one, this could happen. As teachers we are not experts in this field. But we are not being expected to gain what a music therapist would gain. In mainstream schools our input is quite small. I'm quite sure you are not going to have a music therapist coming into a school and saying, "Who do you think you are, you're just a music teacher!" I'm quite sure they would welcome assistance. Certainly any therapists I have come across have been very sensitive and understanding people - otherwise they wouldn't be therapists in the first place! So I don't think there would be a problem of rivalry.

I The implementation of Access Level within the Higher Still programme means that those pupils with even the most complex and profound needs will, literally, have access to Higher Still units of work and assessment procedures. This means that music teachers (as well as teachers in special schools who have a particular skill or interest in music) will now be required to provide such units of work. Do you welcome this? Are you excited by this? Do you think that this in the best interests of the pupils?

MEd1 Yes, I welcome the idea of reaching out and including more pupils. The big concern that I have with Higher Still is how it is to be so concept-based. Is this also the case with Access level?

I I would hope not.

MEd1 I mean the whole idea of composing from concepts, I think it's back-to-front because you compose what comes out from inside you first of all. Yet our concern is that the pupils are going to get their grades. I'm uneasy about teaching in this way. I hope this is not going to be the case with Access level.

I Yes, there will be concepts at Access level but I think that there will be more emphasis on the musical experience and then noticing how concepts can come out of this experience.

(We then spend some time discussing the issue of concepts. It is clear that she is in favour of the principles of Access level but is very concerned about the teaching approach (concept-based) that seems to be part of all levels within Higher Still.)

I Which do you think should be given the highest priority: the development of more postgraduate courses in music therapy - as in Nordoff-Robbins, for example - or the introduction of more training opportunities for music teachers to provide them with the skills and experience necessary to work effectively in the special needs' field?

MEd1 It's very difficult to prioritise here. I think there has to be both. But as we were saying earlier, I think there must be a compulsory input on music therapy as part of music education courses.

I Is there anything further you would like to say?

MEd1 Just that my interest and experience in this area has made me more patient. It has also made me consider more carefully the expectations that I have for the pupils as well as for myself. Perhaps they are sometimes too high, although this is not necessarily a bad thing. I'm just now more conscious of what my expectations are.

I Thank you very much.

END OF INTERVIEW